State Title V Block Grant Narrative

The following PDF was created from the most up-to-date electronic files available from the State for its Title V Maternal and Child Health Services Block Grant 1999 annual report and 2001 application. Some changes in fonts, formatting, page numbers, and image quality may have occurred during the conversion of the document to a PDF.

Sections 5.4 – 5.7, containing standard forms and detailed descriptions of national and State performance and outcome measures, are not included in this PDF. Data from these sections can be viewed in interactive formats on the Title V Information System Web site (http://www.mchdata.net).

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1.3 Table of Contents

1.4 Overview of the State

The seven islands of American Samoa lie just below the Equator, approximately 2,300 miles southwest of Hawaii and 1600 miles northeast of New Zealand. American Samoa is the only United States territory in the Southern Hemisphere. The estimated mid-year population of the Territory as of July 1, 1997, was 59,600. The Territory experiences a **2.5** percent annual growth rate and a fertility rate of **4.5** per 1,000 women. Census projections estimate the current population, year 2000, to be approximately 63,000 people. The majority of the population lives on the main island of Tutuila. Tutuila is nearly 18 miles long and just less than 3 miles wide at its widest point.

Two of the islands of American Samoa are atolls, one of which is a marine wildlife and bird sanctuary called Rose Island, and the other, Swains Island, is owned by an individual family. Swains Island is currently inhabited by less than twenty persons and is used primarily for coconut production.

The other five islands are of volcanic origin, with steep mountains rising sharply from the sea. Geologically, the island group is a chain of submerged dormant volcanoes with only the peaks rising above the ocean's surface. This topography allows for comparatively little flat land for agricultural production and for industrial, commercial and residential development. Virtually the entire population is concentrated in villages that are located along the narrow strip of flat land that fringes the coastlines of these volcanic islands. A dense tropical forest covers the mountainous interiors of the islands.

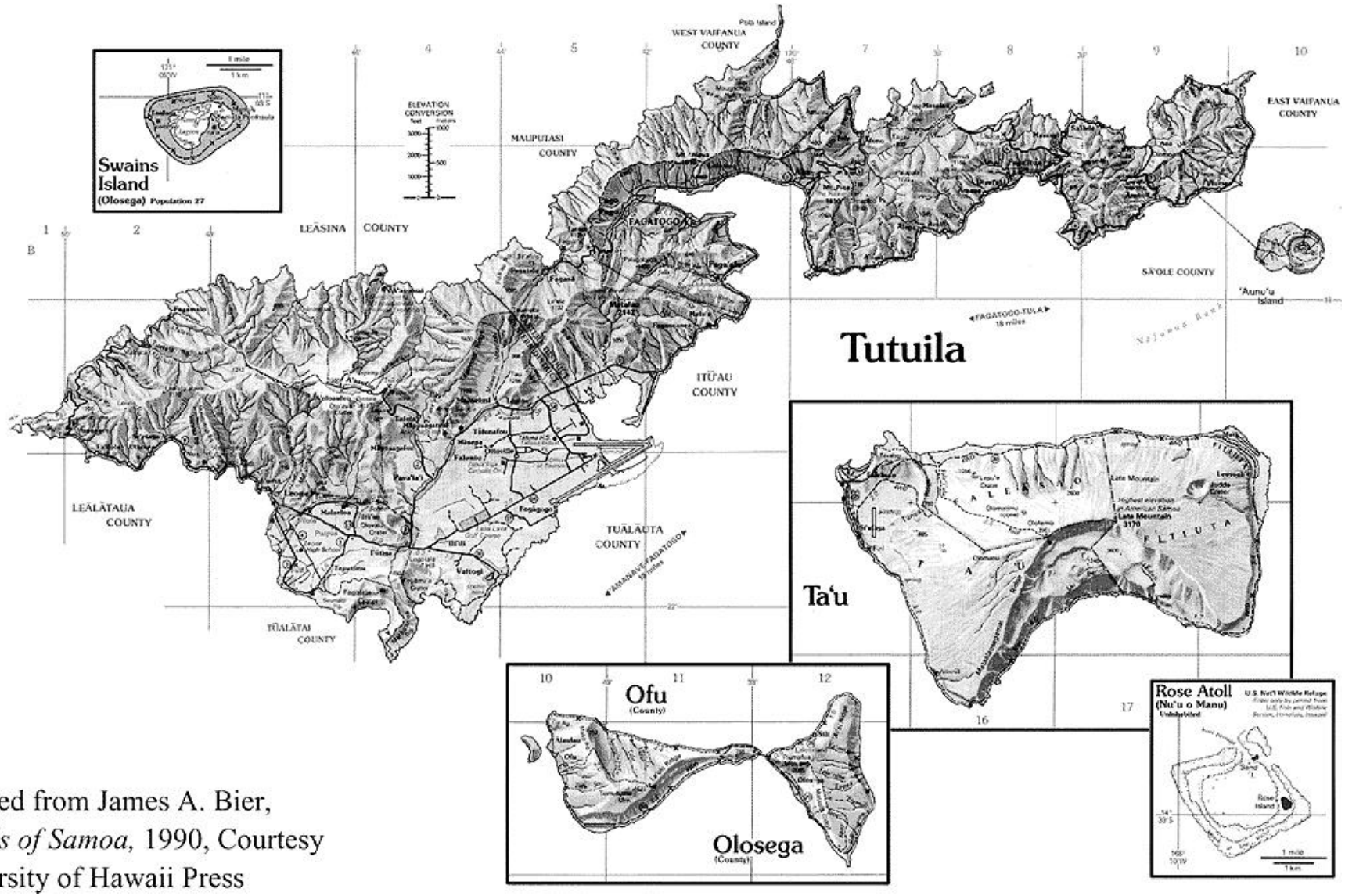
The climate of American Samoa is tropical with two distinct seasons. The first is a relatively cool dry season coinciding with the fall and winter months of the southern hemisphere, and the second is the hot, humid and rainy season coinciding with the spring and summer months (October through March). The heaviest rainfall is concentrated in the months of December through March, and the average annual rainfall is 160 inches. Summer months are also the hurricane season in American Samoa.

Statistical data show that the percentage of the overall population actually born in the Territory has decreased, reflecting an increase in migration. In 1980, 58.3 percent of the population was born in the Territory as compared to 54.7 percent in 1990. A perception of the island Territory as being economically prosperous with a higher standard of living and increased work opportunities as compared to the relative lower standards of living among the neighboring island nations is largely responsible for this increase in migration.

The population density of American Samoa is relatively high, about 774 people per square mile or 298 per square kilometer. This, however, is greatly intensified by the fact that the majority of the population is concentrated on less than 20 percent of the total land area of the territory. The population of American Samoa is also relatively young. The median age for the territory is 21 as compared to 33 for the U.S. population.

Social and cultural environment

Despite the effects of modernization and the heavy influence of materialism, the “fa’a Samoa” or the “Samoan way” still shapes daily life and remains a point of honor and cultural identity to



Adapted from James A. Bier,
Islands of Samoa, 1990, Courtesy
University of Hawaii Press

most Samoans. Fa'a Samoa reflects a complex social order, belief system and system of conduct which have survived since ancient times. Outsiders ignorant or insensitive to the demands of fa'a Samoa can be frustrated in their efforts to conduct business or implement programs locally.

At the core of the fa'a Samoa is the "aiga", an extended family headed by a "matai" or chief. Those related by birth, adoption, or marriage are recognized as belonging to one aiga, which may include hundreds of people. One's sense of identity, happiness, welfare and economic security, in large measure, are derived from the cohesiveness and strength of the aiga.

Another important component of the fa'a Samoa is the matai system, a pyramidal organizational structure which depends on a matai as administrator of the aiga. Elevation to the position of matai is based on a combination of factors including heredity, popularity, and ability. The authority of a matai is generally unquestioned, and he is expected to assign tasks, determine kinds and amounts of donations, allocate communal land, settle disputes and bring honor to his aiga. Respect for seniors and obedience to the matai are considered primary responsibilities of all members of the aiga.

Samoan villages tend to have well defined boundaries and are composed of various aiga, each with a matai. Villages are governed by a "fono" or council composed of matai. Within a village or district the matai system extends upwards in a pyramid model to include high chiefs, high talking chiefs and paramount chiefs.

A more modern yet significant element of the social structure is the widespread adoption of Christianity. Samoans embrace Christianity and incorporated it into their traditional culture with great enthusiasm. There are churches of various denominations in most villages and Samoans spend long hours in various worship activities. The ministers or faifea'us are highly influential and have a great deal of power within a community. For this reason, outreach activities to the community are often based within the context of the church.

Economic Environment

The economy of American Samoa is highly dependent upon the United States, receiving subsidies of more than $50 million per year. American Samoans account for approximately 46 % of the overall labor force while Western Samoans account for 38%. The Territorial government employs approximately 40 percent while the islands two tuna processing and packing plants employ approximately 20 percent. The minimum wage for various industries is reviewed every two years. In 1996, minimum wages ranged from a high of $3.75 per hour to a low of $3.36 per hour for those in the fish canning and processing industry. The U.S. Bureau of Census has determined that approximately 60 percent of the population of American Samoa is below the poverty level.

The 1990 Census indicated that there were 6,607 households in American Samoa, 56.5% of which lived below the poverty level. Median income for males aged 16 and over in 1989 was $7,151 and $5,952 for females. Median household income in 1989 was $16,114. Per capita income for the same year was $3,039. Median income for year-round, full-time workers in 1989 was $7,767 for males and $6,618 for females.

- **The percent of all persons qualifying for poverty status according to Federal guidelines was 58.6%.**
- **More than 90% of families below the poverty level had children under 18 years of age.**

Communication

Within the past few years, a local server began to offer Internet access. While many government agencies and some other organizations have begun to use the Internet as a means of accessing communication and information, it's use as a means to communicate from such a remote island, is yet under-developed. At times, the local server is down for maintenance and troubleshooting for extended periods of time. The Health Department is, therefore, linked to the server at LBJ Tropical medical Center and experiences fewer problems and "down time" as a result.

Many families on the island do not have use of a telephone. Sometimes one telephone is used as a contact number for an entire cluster of houses. Other families use the telephone at small bush stores for occasional phone calls. Many other families simply have no real need for a telephone and, therefore, rely on word of mouth, or the radio and TV for accessing information.

The American Samoa Health Care System

- **Title V**

Until very recently, the Territorial health system was a unified, government owned and operated, centrally controlled system, which included health promotion, disease prevention, environmental protection and acute care diagnostic and treatment services. All health services were delivered through the Health Department, which was comprised of the island's only hospital and the Division of Public Health. In 1998, the Executive Branch initiated a division between the Hospital and Public Health by creating the Hospital Authority as a separate entity from the government.

LBJ Tropical Medical Center is the only hospital in the Territory. In the past few years, a few general practice physicians have opened offices in the private sector offering evening hours. LBJ Tropical Medical Center houses a pediatric clinic, OB/GYN clinic/ and ENT clinic, a medical clinic, surgical clinic and a dental clinic in addition to an emergency room which functions more like a general practice day clinic. An operating room and delivery nursery suite are located within the hospital complex and approximately 98% of all births take place within the hospital.

Basic preventive health services are delivered through 5 village dispensaries which are operated by the Department of Health. All health promotion and prevention services are offered free of charge to the public while acute care services are heavily subsidized by the American Samoa Government. The entire population of American Samoa is provided health care services regardless of ethnicity or income status. However, many other factors adversely influence access to health care:

- Remoteness of many areas of the island
- Lack of good roads in rural areas

- Lack of transportation to many rural areas.
- Cultural isolation in the case of Tongans, Western Samoans and Fijians.

Each categorical program funded by federal grants generally provides the health education efforts on the island. The Health Department is the grantee for a number of federal grant programs such as, Preventive Health Services Block Grant, HIV Prevention, Diabetes Control, TB Elimination, Tobacco Control and several others in addition to Title V: Maternal and Child Health Block Grant (MCH Block) and State Systems Development Initiative (SSDI). Health education at the village level or through use of the media tends to focus on the very specific issues of the program it is initiated by. Each of these federal programs, however, increases the Health Department's ***capacity*** by reaching the Title V population through health education and screening efforts specific to the individual program.

Title V operates within this overall context by providing preventive health primary care services to the Territory's population of women, infants, children and children with special health care needs. The Title V Administrator works closely with the Director of Health and Department Health Planner as well as the Health Information System Division in order to determine the importance, magnitude, value and priority of competing factors upon the environment of health services delivery in the Territory. The Health Information System in collaboration with SSDI is currently working towards the development of a comprehensive data collection system which will ultimately contribute to the overall health planning and resource allocation process. American Samoa is a small island Territory where collaboration is relatively easy and an increasingly close working relationship with the hospital contributes positively to the overall system of health care delivery to the population. The Title V administrator serves as member of the Child Health Insurance Initiative (CHIP) Planning Committee. As such, she is able to advocate for the Title V population and provide related health status data used in the planning process for allocation of CHIP funds. In this current year, CHIP funds will provide financial support for the Territorial Dental Health Initiative which will include the hiring of 5 Dental Officers (graduates from the Fiji Program) 6 dental assistants, an orthodontist and some essential dental equipment for the outer islands of Manu'a.

This description of the physical and cultural environment in American Samoa is meant to describe the overall context in which the development of the Title V program takes place. Often times, programs are developed at the national level with certain assumptions about the political, economic and cultural environment in the respective “States.” As a small island Territory in the Pacific, American Samoa offers a unique setting in which to implement a program with a national emphasis. To ignore the very unique environment of the Territory overall and the health care environment more specifically, would be an error, which would seriously compromise program success. It is the overall goal of the Health Department to develop Title V programs, which are replicable in all states and Territories, while also reflecting the very unique setting which ***is*** American Samoa.

1.5 The State Title V Agency

1.5.1 State Agency Capacity

1.5.1.1 Organizational Structure

The Department of Health is one of 30 Departments in the overall Territorial Government. As such, the Director of Health serves on the Governor's cabinet and acts in an advisory role to the Governor with all matters pertaining to health issues in the Territory.

The Title V MCH Project Coordinator is placed directly under the Director of Health. The MCH project Coordinator/Director of Public Health Nursing oversees the implementation (administration) of all programs with allotments under Title V, including CSHCN.
(see attached organizational chart)

Statutes Relevant to the Title V Program

The Juvenile Act of 1980 - This legislation combined and revised laws pertaining to children. Included in the legislation was a definition of children endangered by child abuse, neglect or sexual abuse. The Act clarified the government's role in protecting children and the Department of Health was given the primary role in providing relevant services under this law.

Immunization Legislation - In 1982, legislation was enacted which required proof of immunization status to be verified by the Department of Education prior to allowing children entrance into school.

Establishment of the American Samoa Hospital Authority - In 1998, the American Samoa Hospital Authority was established in order to create a semi-autonomous hospital authority governed by a Hospital Board.

Legislation Defining the Powers and Responsibilities of the Department of Health - (1998) Subsequent to the establishment of the Hospital Authority, legislation clearly defined and established the role of the Health Department as being separate and distinct from the Hospital. (Prior to this, the Hospital and the Health Department were unified under one Department) Administration of federal programs, including Title V remained under the administration of the Department of Health. This legislation also re-established the authority of the health Department over the Community Health Centers while giving the Department clear authority to initiate demonstration/pilot projects.

Impact of Legislation

The Immunization law specifically impacts Title V programs by clearly establishing the Health Department as the enforcing agency together with the
Department of Education. Immunization rates however require improvements due to a lack of enforcement of this law.

The re-organization of the Health Department resulting in the establishment of the Hospital Authority has had very little or *no* impact on the actual delivery of preventive health and primary care services to the Title V population. Activities, which are carried out by LBJ Tropical Medical Center, continue to be conducted with very little or no changes. Prenatal care has, historically, been provided in the

busiest prenatal care site which is located at the OB Clinic within LBJ Tropical medical Center. This prenatal care clinic continues to be carried out with no changes. The Hospital Authority provides this service within the scope of OB services and Title V clients receive this service without charge. Only a small administrative fee is charged per hospital visit, similar to all other services provided by the hospital.

The Medical Director of the Hospital Authority has been and continues to be very supportive of Title V programs and the Health Department leadership has maintained and fostered a positive working relationship with him. This positive working relationship is further evidenced by the recent appointment of the Hospital Dental Services Division to carry out Title V dental health activities.

The only readily apparent change which has adversely effected the Health Department and Title V to some extent, is that the Medicaid funds have been limited to an overall amount of $250,000. per annum for Health Department supplies and utilities. In the past, the Medicaid funding for these purposes were without specific limit.

Sharing of data continues to be a problem, which is not fully rectified. This has been a problem regardless of legislative changes establishing the Hospital Authority. Title V staff have difficulty obtaining log books in order to gather data relevant to the Title V population from the various wards and Departments.

1.5.1.2 Program Capacity

Pregnant women, mothers and infants-
Program capacity for this population group includes well baby/well child clinics, immunization services, and pre-natal and post-partum clinics. These services are provided in the 6 dispensaries located on the main island of Tutuila and the outer islands of Manu'a. The Public Health and MCH staffs provide physical evaluations, conduct screenings for risk factors, and provide health education on a variety of topics including nutrition, common infectious diseases, breastfeeding, family planning and healthy pregnancies. The MCH Health Educator visits the prenatal and postpartum clinics weekly to discuss poor prenatal outcomes and to provide general counseling on a wide range of topics Further, individualized, health education is conducted on a case by case basis.

The health education team develops health education materials for translation into Samoan. Flip charts have been produced which cover the following topics: discomforts of pregnancy, what to expect at first visit, "healthy do's and don'ts during pregnancy," and breastfeeding tips. The Team has also produced a pamphlet specifically related to prenatal care. This pamphlet is translated into Samoan. The Nutrition Program translates health education materials into Samoan language as well. Topics include "5 a Day," breastfeeding and other general nutrition information. Radio spots concerning early prenatal care are aired in both English and Samoan. The Health Education Team also uses educational videos at the dispensary regarding pregnancy and prenatal care.

Posters and pamphlets are important teaching tools during health education campaigns and individual teaching episodes alike. Translation into Samoan and other Pacific Region languages are an important component of the services provided by Title V.

All high-risk pregnant women who are referred from other health services are provided appropriate health education. Health education is provided in the following areas: nutrition, anemia, basic hygiene, weight control, toxemia, gestational diabetes, hypertension, breastfeeding and prenatal care.

Public education activities include the use of mass media such as TV, radio, and newspaper to promote healthy lifestyles and to enhance awareness of maternal-child health issues, and proper nutritional practices. Hemoglobin assessments for anemia screening of children six months and older is provided during well baby and child clinic and at WIC assessment. Women are also assessed for anemia and other problems in the postpartum period at the village dispensaries. Further, the MCH Social Worker provides health education to all couples seeking a marriage license. Topics covered include family planning and early initiation of prenatal care.

The Nutrition Program promotes physical fitness through supporting and promoting regular aerobics programs in different sites (6 elementary schools plus other government agencies) and monitoring the progress of participants by measuring weights and blood pressures every three months. The Nutrition Program works in collaboration with the Diabetic Program in order to establish walking groups in villages to promote physical fitness and monitor the effectiveness of activities by checking weights and blood pressures at program initiation and weekly thereafter. Breastfeeding education and nutritional counseling are made available to all prenatal and postpartum clients throughout pregnancy and after. These services are provided in health centers, at LBJ Tropical Medical Center, and at WIC. In the past, MCH has assisted in the development of breastfeeding health education modules for the maternity ward nurses to use with women who are being discharged. The delivery and consistency of health education concerning breastfeeding is monitored by Title V.

MCH staff members attended several off-island and on-island workshops. These workshops and meetings focused on the provision of services to the target population and their increased effectiveness. Further, off-island consultants were contracted to provide guidance on appropriate provision of MCH services and the creation of systems to increase program effectiveness. Policies and procedures on selected screening programs are being developed and implemented for mothers, infants and children who attend well-baby/well-child clinics. This system will soon be implemented and future plans include the development of a similar system for prenatal/postpartum clinics.

Children

The American Samoa Department of Health conducts well baby/child clinics in the various dispensaries, this includes the outer islands as well as the newly

constructed and operational Amouli dispensary. To further expand Department capacity to provide well baby/child care, the MCH Program also expanded its medical staff by adding an additional physician to equal 3 MCH practitioners (2 physicians and a nurse practitioner). The Maternal and Child Health Program provides most of the resources such as supplies and staff for all dispensaries. In well baby/child clinics weight, height, and head circumference are measured. Each child is assessed for developmental status, immunized, and given a physical exam by the MCH physicians and nurse practitioners at the one month and nine months visits. Public Health nurses assess children ages 2 months, 4 months, 6 months, and 15 months.

Health education provided by the Public Health nurses is based on the specific need of each individual child. When a child comes to a dispensary with a specific complaint, the caretaker is provided with information related the specific ailment. General information related to the child's overall growth and development is reserved for the scheduled well baby/well child visits.

The MCH Nutrition staff delivers one-on-one health education with caretakers of children 1 month old, 6 months old and 1 year old. Children are also screened for hemoglobin. Those with results below recommended levels are referred to the MCH physician for further evaluation. The caretaker is given health education on the appropriate nutritional need of the child after hemoglobin is checked. Hemoglobin levels are routinely checked at 6 months of age. Those children with low hemoglobin are provided counseling and iron supplementation and followed up one month later for a re-assessment. Children with hemoglobin levels below 10 are given nutritional counseling and are re-assessed one month later. Those children with levels below 9 are provided with a prescription for iron supplements and are re-assessed one month later.

MCH provides educational material on proper skin and oral care, as well as prompt immunizations. Radio spots on dental care, immunizations and prenatal care are aired regularly. Health related TV programs are aired as a public education effort on topics related to baby and child care, injury prevention, etc. Title V also provides appropriate referral services for children screened by the School Health Team who require medical attention. MCH also coordinates efforts with the Dental Health Program to provide sealants for grade school children. The MCH Nutrition Program, in collaboration with the WIC Program, offers nutritional education to children and others in the WIC target population.

Population-based services targeted towards children include the provision of immunization clinics as well as other health education and health promotion activities. Daily immunization clinics are scheduled with well child clinics throughout the six dispensaries that serve the Tutuila and Manu'a population. Collaborative services of MCH School Health Team and Early Childhood Education (DOE) provide full health assessments which include dental screening for school children. The MCH School Health Program refers children with dental problems to the dental clinic for treatment. Sealants are provided for children in the third. This represents a cooperative effort between MCH and the dental outreach team.

American Samoa law requires that everyone is entitled to medical care at no or minimal costs. MCH provides immunizations, well child health screening, school health and village-based screening, prenatal and post-partum care, and health education. In an effort to improve the quality of care provided to MCH populations, procedural standards and policies for immunization and nursing care have been implemented at the dispensary level. Continuous training for MCH staff on well child care and immunization were conducted. MCH staff were also involved in workshops conducted by the MCH Consultant which included the selection appropriate indicators for the 5 Year MCH needs assessment and ongoing discussions of the MCH performance and outcome measures.

Children with Special Health Care Needs

Title V provides assessments of those children who are screened positive for having a possible chronic or disabling condition. Most assessments are conducted in the child's home, which is less threatening and less disruptive for the family than the clinic setting. Those children with chronic and debilitating conditions and their families are given special support and services through the CSN Program. The overall goal of the CSN Program is to encourage and empower children with special needs to live within their communities in an acceptable way and live to their fullest potential.

Occasional assessments and reviews are held during Well Baby Clinics. These assessments and reviews involve a holistic approach with counseling and advice on a range of issues: a. those relating specifically to the disability e.g. stimulation, positioning and handling, safety and b. those relating to general health e.g. immunization, hygiene, skin and dental care. Other direct services include: (a) In cooperation with Special Education services of the Department of Education, assistance given in developing family management plans and/or Individual Education Plans (IEP) either in school or at home visit. (b) Advice about special management, handling techniques and equipment was provided to teachers working in special education classes and teaching CSHCN in normal school classes. (c) Some gap filling medical treatment especially for epilepsy and muscle spasm is provided for individual patients during review assessments. (d) Regular visits are made to the respite care center in order to provide direct medical services for the severe and multiply disabled. The team members arrange referrals and facilitate access to other agencies or services to help meet particular CSN requirements. These include family support services especially WIC and American Samoa Nutrition Assistance Program (ASNAP), Department of Social Services, Child Protection Services, medical specialty services (eye, ENT, orthopedic and pediatric), Department of Education Special Education Services, and arranging respite care services provided by a private, Catholic, respite care home on island.

The CSHCN Team also presents informational sessions to LBJ staff during..medical staff meetings. The program also participates in informational television programs on CSN issues and offers information on the Territory's CSN program.

Village clinics are also conducted. Theses "village clinics" entail CSN staff, nutrition staff and Head Start going to the village meeting houses in order to present outreach education sessions as well as doing complete assessments for Head Start.

The State Systems Development Initiative (SSDI) Project, in cooperation with the MCH Block programs, has initiated consultations provided by an MCH Consultant on a variety of infrastructure building activities including a comprehensive system of care for the CSHCN population. Further, MCH Staff and CSHCN program staff have participated in numerous on-island as well as off-island continuing education training.

In cooperation with University Affiliated Programs (University of Hawaii) teleconferencing is utilized in order to provide consultation to CSHCN clients. Professional participants in the consultation have included a speech pathologist, a geneticist, as well as a nutritionist. The teleconferences are used in order to interview CSN patients and their families in order to evaluate overall health status and give recommendations on continuous care.

- American Samoa does not receive SSI benefits
- The CSHCN Program provides and promotes family-centered, community-based, coordinated care including care coordination services, for CSHCN and facilitate the development of community based systems of services for children and their families through he Interagency team which provides a comprehensive spectrum of services to this population.

1.5.1.3 Other Capacity

Title V staff include 20 full time employees, inclusive of central office staff as well as out-stationed staff. In addition to Title V leadership, staff are organized into the following programs:

- Prenatal
- Well Baby
- CSHCN
- Social Services
- Health Education
- Immunization
- Dental Health Services
- Nutrition

In addition to the above mentioned 20 staff members who deliver services to the population of women, infants and CSHCN, Title V leadership staff include the following:

- **Dr. Joseph Tufa, DSM, MPH**
  Director, Department of Health

Dr. Tufa is a graduate of the Fiji School of Medicine (1976). He began practicing medicine at LBJ Tropical Medical Center in 1976 upon completion of his degree. He practiced as a member of LBJ staff until 1995. In 1994, however, he left the island to pursue advanced studies in Public Health and received his Masters in Public Health from the University of Hawaii School of Public Health in Manoa, Honolulu. Upon his return to the island, he was appointed as Deputy Director of Public Health. He has served in the position of Director of Health since 1998.

- **Ms. Diana Pilitati Tuinei, BSN, RN, MPH**
  MCH Coordinator, Director, Public Health Nursing
  Ms. Tuinei graduated from an RN Diploma program in Auckland, New Zealand in 1955. She worked in Maternity Nursing field for 9 years in both California and American Samoa. In 1968 she was an ER nursing supervisor at LBJ. In 1973, she became Director of Public Health Nursing, responsible for all nursing services and all federally funded programs under nursing. In 1979 she obtained her Bachelors' degree in Social Studies from Brigham and Young University. She completed her Masters in Public Health in 1982. In 1981, she became the MCH Coordinator and has acted in this capacity since this time.

- **Ms. Tu'u Maiava, BSN, RN**
  Quality Assurance Specialist
  Ms. Maiava graduated from Arizona State University in 1990 with a Bachelor of Science degree in Nursing. In 1992, she returned to the Territory in order to assume the position of MCH Health Educator. She held this position for 5 years at which time she was selected as Quality Assurance and In service Specialist for Public Health nursing. In this position, she assists in the development of policies, revision of policies and works closely with the MCH Consultant on the development of healthcare delivery systems to the Title V population. Additionally, she coordinates and conducts in-service training sessions to the nursing staff (both in-posted and out-posted) who are responsible for the delivery of services to the Title V population.

1.5.2 State Agency Coordination

The following Territorial Human Service Agencies are represented in American Samoa and are all under the jurisdiction of the Territorial government with the exception of LBJ Tropical Medical Center which is under the Hospital Authority, a semi-autonomous agency:

- Hospital Authority - LBJ Tropical Medical Center
  - LBJ Tropical Medical Center Administrative Services - The Administrative Services of LBJ works with Title V by providing opportunities for tele-health video conferencing. This enables the Title V staff to consult with off-island consultants, participate in continuing education workshop opportunities etc. Further, the Health Department is able to connect to the LBJ Internet server in order to have continuous access to the internet.

- OB/ Prenatal Care Clinic - The OB/Prenatal Care Clinic provides prenatal and postpartum care for the population of pregnant women living in the service area as well as follow up for high-risk cases which are referred to that Clinic.
- Mental Health - This is a department of LBJ Tropical Medical center. Mental Health Services possess the ability to diagnose and administer treatment to mentally ill clients.
- Part C - The MCH Coordinator is a member of the interagency council for Part C. Title V staff who work with CSHCN coordinate services with Part C in the development of the Individual Family Service Plans. Part C staff provide services to the Title V population. (play therapy, assistance in the development of Individual Family Service Plans etc.)
- Title XXI - Family Planning - Provides family planning services to the population of Title V. Furnishes data for program use.

- Department of Human and Social Services - the Department of Human and Social Services is a Department of the Territorial Government. As such, the Director serves as an advisor to the Governor on all matters pertaining to the social services sector. As such, activities are coordinated between the Department of Human and Social Services and the Department of Health in the delivery of services to the Title V population and the provision of necessary data items in satisfaction of federal data requirements. The following divisions of the Department directly serve the Title V population:
  - WIC - the Supplemental Feeding Program for Women, Infants and Children offers nutritional education and counseling for mother and baby, breastfeeding education, developmental information for babies. Further, an in-house public health clinic offers comprehensive prenatal care. WIC assists the Title V programs in meeting data requirements in satisfaction of federal data reporting requirements.
  - Developmental Disabilities Planning Council - Acts as a member of the interagency team focused on meeting the needs of children with special health care needs. Assists families in the development of the Individual Service Plans.
  - Division of Vocational Rehabilitation - Acts as a member of the interagency team focused on meeting the needs of children with special health care needs.
- Department of Education - assists in the provision of data, YRBS, assists in the enforcement of the child immunization law, assists in the coordination of the School Health Outreach Team as well as other school-based health education activities.
  - Special Education - Assists in meeting the service needs of the CSHCN population, assists in assuring that all services are provided to the CSHCN population, acts as a key member of the interagency team focused on the needs of CSHCN, assists in the development of Individual Family Plans for families of CSHCN.
  - Early Childhood Education - Acts as a representative on the Interagency Leadership team which addresses needs of CSHCN, Assists in the enforcement of the Immunization law prohibiting children form entering school without immunization program clearance
  - Elementary Education - assists in the coordination of efforts provided by the School Health Team, assists in the enforcement of the Immunization Law prohibiting children from entering school without complete immunizations,

serves as a member of the Interagency Leadership Team, assists families in the development if Individual Service Plans.

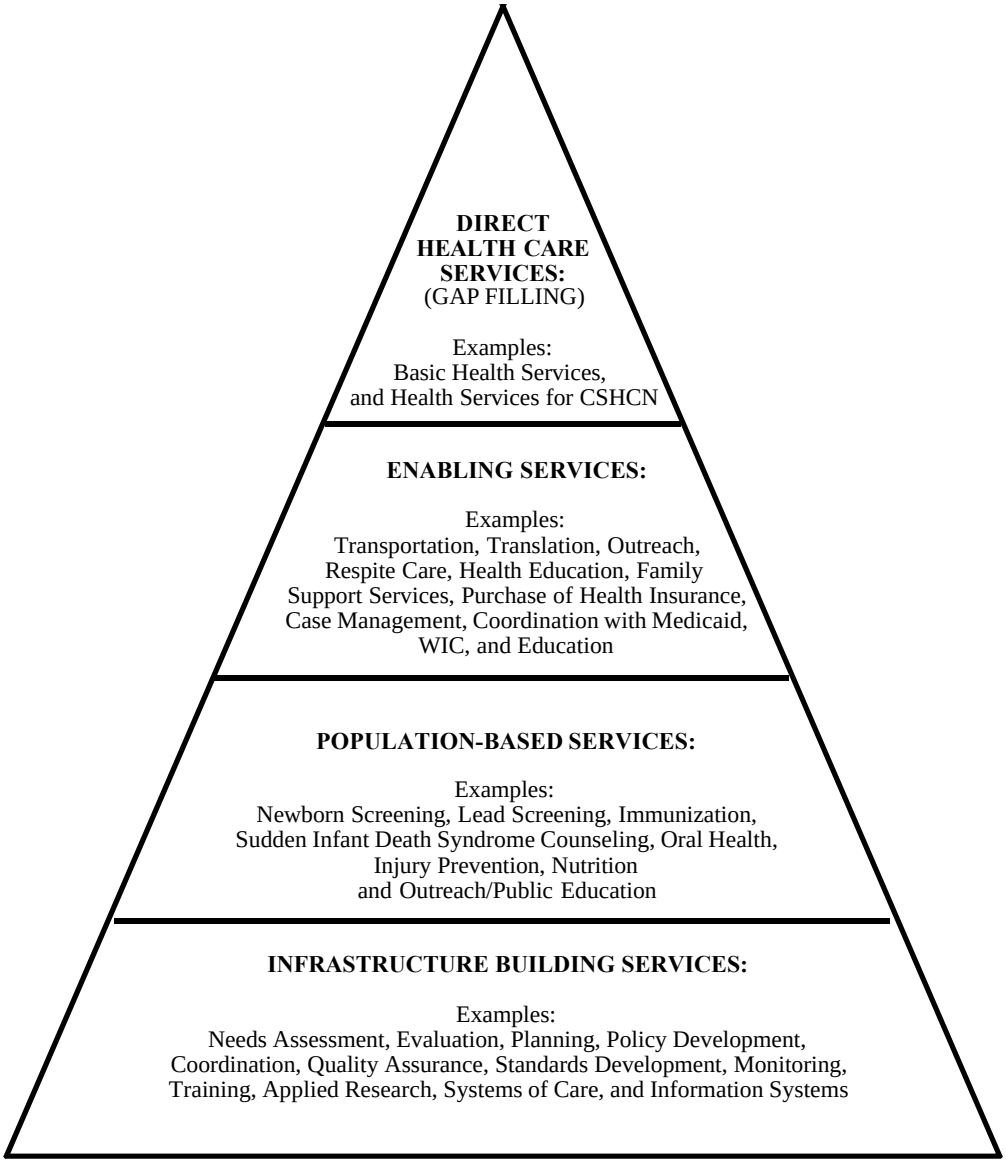
- Office of Protection and Advocacy for the Disabled - Acts as a representative on the Interagency Leadership team which addresses needs of CSHCN.

II. REQUIREMENTS FOR THE ANNUAL REPORT

2.1 Annual Expenditures

Figure 2

CORE PUBLIC HEALTH SERVICES DELIVERED BY MCH AGENCIES



MCHB/DSCH 10/20/97

2.2 Annual Number of Individuals Served

2.3 State Summary Profile

2.4 Progress on Annual Performance Measures

The discussion of the accomplishments of the Maternal and Child Health Program's performance measures for 1999 is presented in the four areas of direct health services, enabling services, population-based services, and infrastructure building services. Each of the areas has included a discussion of the three specific populations of pregnant women, mothers, and infants; children; and children with special health care needs.

DIRECT HEALTH SERVICES– The major activities of the staff in the MCH Program are related to the provision of direct health care services. Because of the unique situation in American Samoa where the government has the responsibility for providing the direct services, much of the services are provided through the Public Health programs.

Pregnant women, mothers, and infants – Health care services provided for this population group include well baby/well child clinics, immunization services, and pre-natal and post-partum clinics. These services are provided in the 6 dispensaries located on the main island of Tutuila and the outer islands of Manu'a. The Public Health and MCH staffs provide physical evaluations, conduct screenings for risk factors, and provide health education on a variety of topics including nutrition, common infectious diseases, breastfeeding, family planning and healthy pregnancies. The MCH Health Educator visits the prenatal and postpartum clinics weekly to discuss poor prenatal outcomes and to provide general counseling on a wide range of topics including sexually transmitted diseases, fetal growth and development, benefits of early prenatal visits; general hygiene including dental care, skin care - identification of skin rashes especially fungal lesions, negative effects of behaviors such as smoking, alcohol use, drug use, family planning services, etc. Health Education, which is provided as a direct health service, is conducted on a case by case basis.

Children – In 1999, there were a total of 1,736 births in American Samoa. In FY 1999 there were 387 well child clinics conducted by the American Samoa Department of Health in the various dispensaries, this includes the outer islands as well as the newly constructed and operational Amouli dispensary. The MCH Program also expanded it's medical staff by adding an additional physician to equal 3 MCH practitioners (2 physicians and a nurse practitioner). The Maternal and Child Health Program provided most of the resources such as supplies and staff for all dispensaries. It is estimated that 13,604 children were seen in these clinics. In well child clinics weight, height, and head circumference are measured. Each child is assessed for developmental status, immunized, and given a physical exam by the MCH physicians and nurse practitioners at the one month and nine months visits. Public Health nurses assess children ages 2 months, 4 months, 6 months, and 15 months.

Health education provided by the Public Health nurses is based on the specific need of each individual child. When a child comes to a dispensary with a specific complaint, the caretaker is provided with information related the specific ailment. General information related to the child's overall growth and development is reserved for the scheduled well baby/well child visits.

The MCH Nutrition staff delivers one-on-one health education with caretakers of children 1 month old, 6 months old and 1 year old. Children are also screened for hemoglobin. Those with results below recommended levels are referred to the MCH physician for further evaluation. The caretaker is given health education on the appropriate nutritional need of the child after hemoglobin is checked. Hemoglobin levels are routinely checked at 6 months of age. Those children with low hemoglobin are provided counseling and iron supplementation and followed up one month later for a re-assessment. Children with hemoglobin levels below 10 are given nutritional counseling and are re-assessed one month later. Those children with levels below 9 are provided with a prescription for iron supplements and are re-assessed one month later.

Children with special health care needs – The main activity for the CSN program was the assessment of those children who were screened positive for having a possible chronic or disabling condition. These assessments were held initially at clinics based in the hospital and dispensaries but due to poor attendance, in spite of reminders and due to problems of access most assessments were transferred to the child's home which is less threatening and less disruptive for the family.

Those children with chronic and debilitating conditions and their families are given special support and services through the CSN Program. The overall goal of the CSN Program is to encourage and empower children with special needs to live within their communities in an acceptable way and live to their fullest potential.

Occasional assessments and reviews were held during Well Baby Clinics. These assessments and reviews involved a holistic approach with counseling and advice on a range of issues: a. those relating specifically to the disability e.g. stimulation, positioning and handling, safety and b. those relating to general health e.g. immunization, hygiene, skin and dental care. Other direct services included: (a) In cooperation with Special Education services of the Department of Education, assistance given in developing family management plans and/or Individual Education Plans (IEP) either in school or at home visit. (b) Advice about special management, handling techniques and equipment was provided to teachers working in special education classes and teaching CSHCN in normal school classes. (c) Some gap filling medical treatment especially for epilepsy and muscle spasm was provided for individual patients during review assessments. (d) Regular visits were made to the respite care center in order to provide direct medical services for the severe and multiply disabled.

In 1999, services were provided to 135 CSHCN clients. In last years' application, the total number of CSN was reported as 325. The development of this year's application

revealed that this number was not a reflection of the true number of CSHCN in the Territory. The CSHCN program staff reviewed the individual charts of all clients and classified each child according to their condition. This review of records revealed that 97 children were misclassified under the CSHCN population. These 97 children represented those who had problems outside the definition for the CSHCN group. Further, 47 children among the overall number have been discharged from the Program due to circumstances such as moving away from the island or death.

A total of 47 CSHCN referrals were received from (nursery, pediatric ward, well-baby clinics, Vocational Rehabilitation, Part H, Special Education, school, and family) of which 18 were considered CSHCN. The newborn nursery referred 14 clients; pediatric ward 12; pediatric clinic 0; well baby clinic 14; vocational rehab., 1; Part H 2; Special Education 1; school 2, and from family or friend referral 1.

ENABLING SERVICES - Enabling services are those services that address the barriers that prevent clients and patients from the opportunity to access preventive as well as acute care services. For the population in American Samoa, transportation from the remote villages to the central dispensaries and the hospital may pose a problem for some; for others outreach services, health education, family support, and coordination are essential to receiving care.

Pregnant women, mothers, and infants – The health education team creates health education materials and translates them into Samoan. Flip charts have been produced which cover the following topics: discomforts of pregnancy, what to expect at first visit, "healthy do's and don'ts during pregnancy," and breastfeeding tips. The Team has also produced a pamphlet specifically related to prenatal care. This pamphlet is translated into Samoan and is undergoing an approval process. The Nutrition Program translated a variety of posters and pamphlets into Samoan. Posters and pamphlet topics include "5 a Day," breastfeeding and other general nutrition information. Radio spots concerning early prenatal care were aired in both English and Samoan. The Health Education Team also uses educational videos at the dispensary regarding pregnancy and prenatal care. Other posters and pamphlets are ready to be translated. Posters and pamphlets are important teaching tools during health education campaigns and individual teaching episodes alike.

All high-risk pregnant women who are referred from other health services are provided appropriate health education. Health education is provided in the following areas: nutrition, anemia, basic hygiene, weight control, toxemia, gestational diabetes, hypertension, breastfeeding and prenatal care.

Children –Using health education materials provided by MCH Health Education Staff, MCH provides educational material on proper skin and oral care, as well as prompt immunizations. Radio spots on dental care, immunizations and prenatal care were aired in 1999 and MCH plans to re-air them in 2000. Health education materials (pamphlets, posters, and flip charts) were translated into Samoan, Tongan, and Filipino (Tagalog). Two TV programs were aired in 1999 on the importance of accessing

regular well-baby care and another program on injury prevention. Appropriate referral services are also provided to children screened by the School Health Team who require medical attention. MCH also coordinates efforts with the Dental Health Program to provide sealants for grade school children. The MCH Nutrition Program, in collaboration with the WIC Program, offers nutritional education to children and others in the WIC target population.

Children with special health care needs – By conducting assessments and reviews in a home setting rather than a clinic setting, the CSN team enabled more children to access the service. The team members arranged referrals and facilitated access to other agencies or services to help meet particular CSN requirements. These included family support services especially WIC and American Samoa Nutrition Assistance Program (ASNAP), Department of Social Services, Child Protection Services, medical specialty services (eye, ENT, orthopedic and pediatric), Department of Education Special Education Services, and arranging respite care services provided by a private, Catholic, respite care home on island.

Through these assessments at the home setting, essential special equipment was also provided. For example, wheelchairs are supplied to enable the child to participate in normal social and family activities especially at school. By cooperating with Special Education, the CSN Team assisted in developing IEP to allow the CSHCN to participate in a school program with other children.

POPULATION-BASED SERVICES – These services are generally the responsibilities of Public Health sector and as such are the major areas of activities for the MCH Program in American Samoa. The MCH Program has an active immunization program, and works in collaboration with the Dental Health Program to provide protective sealants for children; works with the LBJ Hospital to educate mothers on breastfeeding and to assure that pregnant women are screened for Hepatitis B and to immunize susceptible women.

Pregnant women, mothers, and infants – Public education activities include the use of mass media such as TV, radio, and newspaper to promote healthy lifestyles and to enhance awareness of maternal-child health issues, and proper nutritional practices. Hemoglobin assessments for anemia screening of children six months and older is provided during well baby and child clinic and at WIC assessment. Women are also assessed for anemia and other problems in the postpartum period at the village dispensaries. Further, the MCH Social Worker provides health education to all couples seeking a marriage license. Topics covered include family planning and early initiation of prenatal care.

The Nutrition Program promotes physical fitness through supporting and promoting regular aerobics programs in different sites (6 elementary schools plus other government agencies) and monitoring the progress of participants by measuring weights and blood pressures every three months. The Nutrition Program works in collaboration with the Diabetic Program in order to establish walking groups at four

village sites to promote physical fitness, and monitor the effectiveness of activities by checking weights and blood pressures at program initiation and weekly thereafter. Breastfeeding education and nutritional counseling are made available to all prenatal and postpartum clients throughout pregnancy and after. These services are provided in health centers, at LBJ Tropical Medical Center, and at WIC. In the past, MCH has assisted in the development of breastfeeding health education modules for the maternity ward nurses to use with women who are being discharged. The delivery and consistency of health education concerning breastfeeding will continue to be monitored by Title V.

Children – Population-based services targeted towards children include the provision of immunization clinics as well as other health education and health promotion activities. The immunization initiatives were successful when surveyed. Studies show that 75% of children at age 2 completed three Hepatitis B immunizations, 3 Hib, 4 DPT, 3 OPV, and 1 MMR. Daily immunization clinics are scheduled with well child clinics throughout the six dispensaries that serve the Tutuila and Manu'a population. In FY 99, 387 Immunization/Well Baby Clinics were conducted. There were 13,604 children who received all their required immunizations. The MCH and Immunization programs have been very successful in preventing any outbreaks for the past six years.

Collaborative services of MCH School Health Team and Early Childhood Education provided full health assessments which include dental screening for 5,982 school children. The MCH School Health Program refers children with dental problems to the dental clinic for treatment.

Sealants continued to be provided for children in the first, fourth and eighth grade during FY 1999. A total of 2,195 children were seen in a cooperative effort between MCH and the dental outreach team. Of this total number, 1,933 children were provided fissure sealants. The Dental Outreach team targets efforts towards first, fourth and eighth grades.

The following children were screened, assessed, received heath education and received fluoride treatments in 14 schools:

- 642 first graders
- 570 fourth graders
- 225 seventh graders
- 607 eighth graders

The MCH Nutrition Program routinely screens for low hemoglobin in children ages six months and older during well baby care visits. Surveys demonstrate that 35% of children showed some degree of anemia. According to degree of anemia, diet counseling and instructions for obtaining iron supplements are given. At this point a follow-up appointment is given.

Children with special health care needs – Regular screening for potentially chronic and disabling conditions was done through: (1) Well Baby Clinic by the pediatricians

and occasionally by dispensary nurses; (2) twice weekly rounds at the pediatric ward which include the Newborn Nursery and the Intensive Care Unit; and (3) School Health screenings of new entrant students at the ECE level.

From the 4,866 school children screened, there were only two children referred to the CSN Team for further assessment. From the Ward Rounds, 25 children were referred for further assessment and 6 were confirmed CSN. From well baby clinics, 14 were referred for further assessment and 2 were considered to be CSN. From these 41 referrals, 10 were considered to have significant problems.

Health education

- In 1999, CSHCN staff presented informative sessions to LBJ medical staff during scheduled staff meetings.
- Health education sessions take place on a one to one basis according to each individual child and family's needs. All families were reached in 1999.

The program also participated in a 30-minute television program on CSN issues and offered information on the Territory's CSN program. This television program featured the CSN child and her family. Program featured the functions of the CSN team play therapy, safety issues, how to handle a child and how to protect the care giver's back. Suggested activities to do with a special needs child such as toy making were highlighted as well as a variety of other household activities which could safely include a special needs child. This resulted in one referral.

Village clinics were conducted during a period of 6 weeks and included 876 participants. These "village clinics" entail CSN staff, nutrition staff and Head Start going to the village meeting houses in order to present outreach education sessions as well as doing complete assessments for Head Start.

Outreach presentations to the medical staff conducted by the Program has resulted in an increase in referrals to the CSN program. On each occasion, the program receives calls from members of the community with concerns for a child in the family. In 1999, a re-examination of the numbers of CSN children as compared to the definition of the term, resulted in a decrease in numbers of "true" CSHCN enrolled in the program. In 1999, the program determined that it's CSN population is actually 135 as opposed to the 325 reported in the previous year. The program offers services to an additional 49 children considered "non-CSN" but have some other condition such as learning disability while the program also offers services to 48 children who are considered to be high-risk.

INFRASTUCTURE BUILDING SERVICES

Policies and procedures have been developed in the areas of immunizations, well baby/well child services as well as other MCH services. With the assistance of the MCH Consultant, standardized policies and procedures for well baby care have been written and approved by the department. The new policies and procedures are

currently being implemented in the community dispensaries. The Immunization Program policies and procedures are also complete but have not yet been implemented in the dispensaries as inservice training has yet to take place with the dispensary nurses.

Pregnant women, mothers, and infants – MCH staff members attended several off-island and on-island workshops. These workshops and meetings focused on the provision of services to the target population and their increased effectiveness. Further, off-island consultants were contracted to provide guidance on appropriate provision of MCH services and the creation of systems to increase program effectiveness. Policies and procedures on selected screening programs are being developed and implemented for mothers, infants and children who attend well-baby/well-child clinics. This system is currently in the pilot stages and is soon to be implemented. Plans for the coming year include the development of a similar system for prenatal/postpartum clinics.

Children – American Samoa law requires that everyone is entitled to medical care at no or minimal costs. MCH provides immunizations, well child health screening, school health and village-based screening, prenatal and post-partum care, and health education. In an effort to improve the quality of care provided to MCH populations, procedural standards and policies for immunization and nursing care have been implemented at the dispensary level. Continuous training for MCH staff on well child care and immunization were conducted. MCH staff were also involved in workshops conducted by the MCH Consultant which included the selection appropriate indicators for the 5 Year MCH needs assessment and ongoing discussions of the MCH performance and outcome measures.

Children with special health care needs - The State Systems Development Initiative (SSDI) Project in cooperation with the MCH Block programs, continued the consultations provided by Dr. Henry Ichiho on a variety of infrastructure building activities. In 1999, the MCH pediatrician conducted a follow-up seminar with MCH staff, Public Health nursing and the CSN Team on concepts of primary care and the components of a Well Baby care service, and the basic components of the life cycle. Attention was given to the particular considerations for the child with special health care needs. In addition, a three hour workshop was conducted for MCH staff and Public Health Nursing staff on the basic principles of growth and development, interpretation of growth measurements, and how to plot measurements on a growth grid – weight, height, and weight for height.

The CSN Team attended a 6-week training program offered University Affiliated Programs through the University of Hawaii. The training program conducted by Dr. Kathleen Radcliff consisted of safety issues for family members and care providers in handling children with special health care needs as well as creating low-tech adaptive devices with materials available on island. (Hand splints, canes, etc.)

The CSN Team participated in a program offered by the American Samoa Community College on American Sign Language. Staff participated in an introductory session on sign language in order to increase and enhance the ability of the CSN team to communicate with its hearing impaired population.

A thirty-minute TV Program focusing on one CSN family was aired related to performing an assessment and developing an intervention plan with a family-centered focus. The actual case of this family was discussed.

In a later consultation visit, CSN and Well Baby/Child Systems of Services were reviewed and analyzed for problems. An overview and review of the components of the Children with Special Health Care Needs system of services was discussed. Furthermore, problems and issues relating to the improvements in the delivery of services to the CSHCN population were also identified and discussed. Lastly, an action plan was developed to improve the CSHCN system of services.

In cooperation with University Affiliated Programs (University of Hawaii) a teleconference was held in American Samoa at Special Education focusing on 4 CSN cases. Professional participants in the consultation included a speech pathologist, a geneticist, as well as a nutritionist. The teleconferences were used in order to interview CSN patients and their families in order to evaluate overall health status and give recommendations on continuous care.

NATIONAL PERFORMANCE MEASURES

N1 Not applicable to American Samoa

N2 The degree to which the State Children With Special Health Care Needs (CSHCN) Program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients.

The target performance was met in that all nine services on the checklist are provided or are accessible to CSN clients in American Samoa. The CSN Program provides four services directly:

- #2–Physical Therapy services,
- #6–Home Health Care,
- #8–Care Coordination,
- #9–Early Intervention Services.

LBJ Tropical Medical Center provides the following services to the CSN population:

- #1–Medical and Surgical Subspecialty services
- #4–Respiratory Services.

The MCH program provides #7 – Nutrition Services.

The Department of Education, Division of Special Education provides

- #3 – Speech, Hearing and Language Services
- #5 – Durable Medical Supplies.

In American Samoa, health services are available to all residents including CSHCN, free of charge. The American Samoa CSN Program therefore, is not required to provide or pay for services for any specific individual. Available specialty and subspecialty services depend on hospital staffing. If a service is not available on island, an off island referral may be arranged and funded if the need is considered to be justified by the off-island referral committee.

While all health services are free of charge in American Samoa, a small service fee is charged to the individual receiving health services and medications. There is a $2.00 charge for clinic visits, a $3.00 dispensing fee for each prescription and a daily hospital fee for inpatients of $7.50 for residents and $64.00 for non-residents. These charges are sometimes a barrier for those people in lower socioeconomic groups but there are no provisions for the CSN Program to meet this shortfall.

N3 The percent of Children with Special Health Care Needs (CSHCN) in the state who have a "medical/health home".

This performance measure was met in 1999. One hundred percent of CSN children in American Samoa use the CSN program as their "medical home."

Title V played a significant role in this level of accomplishment through both the MCH Block Grant and SSDI Program. Through Title V, vital staff positions are provided for the CSN Program. These positions include 2 pediatricians, and a case coordinator, which are directly provided for under the MCH Block Grant. The SSDI Program provides further essential support for the CSN program by providing a Project Coordinator, computer equipment, supplies etc. Title V also provides funding for supplies as well as administrative support for the CSN Program. The MCH Consultant also provided valuable staff training on case findings and evaluation of CSN cases.

In American Samoa, the CSN Program is a well-known source of information, services and support for children with special health care needs and their families. In a small Island Territory, with health care services provided by the Government, the CSN Program is able to coordinate services for families quite effectively. Families of CSN children have developed a "medical/health home" relationship with the CSN staff because of the frequent home and school visits provided by the CSN Program. When families have concerns, they often contact the CSN Program staff who arrange and facilitate provision of the needed service. This allows for a great deal of individual contact between the CSN Program and CSN families.

N4 Not applicable to American Samoa

N5 Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B.

The target was met in 1999. In 1999, 86% of children through age 2 were fully immunized according to age.

Title V provided general nursing leadership and direction towards the accomplishment of this goal. Further, MCH health education activities contributed to the accomplishment of the target by emphasizing the importance of immunizations. MCH pediatricians conduct assessments of infant's and children's overall health including immunization status. Title V provides staff development activities relevant to immunization. Through MCH Block grant staff, protocols and standards were developed regarding immunization. Title V provides supplies required for immunization services. Finally, the school health team assesses school children's immunization status. In FY 1999, the school Health Team assessed the health status of 4,090 children.

The Department of Health conducted a cluster survey of completed immunization status of 2 year olds. Results show a complete immunization rate of 86%. The immunization Program routinely screens records in order to monitor Program effectiveness. The Program is currently screening immunization records of children up to age 2. All children are immunized at well baby clinics. There are six dispensaries serving American Samoa and 374 well baby clinics were held in FY 98. There were 13,604 children who received all their required immunizations.

Much of the activities centered on immunizations represent a collaborative effort between Title V and the Immunization Program funded by the CDC. There is an annual mass immunization campaign held in June to encourage people to immunize their children appropriately. During this time, television programs and radio spots are utilized to increase public attention and awareness. Throughout 1999, television programs as well as a variety of newspaper articles, and TV interviews were aired on the subject.

In 1999, the policy of "walk-in" clinics was maintained. An immunization "follow-up" policy has been put into place resulting in reminder phone calls being made to families who miss appointments. There are various public service announcements aired on a regular basis, which emphasize the importance of immunizations. MCH Health Educators discuss the importance of immunizations during well-baby clinics. Nurses who work at the village clinics throughout American Samoa give educational information regarding immunizations to those who come in for their appointments.

There are several inservice trainings held for Public Health nurses and MCH staff to ensure updated information on immunizations is being taught to clients and enforced in the schools. The law requires that all children entering schools have records of their completed immunizations.

N6 The rate of birth (per 1,000) for teenagers aged 15 through 17 years.

The target for this measure was set at 18. This target was not met at 24.7 in 1999. Recent YRBS data results (1999) show that 69% of 14-17 year olds are sexually active without using birth control.

There are two programs that actively provide promotional services intended to address and decrease this rate. Family Planning provides educational materials on contraceptive methods that are free of charge in order to help avoid or reduce teen pregnancy. Specific activities undertaken include school visits, community outreach, use of the mass media (TV, radio, and newspaper) and lectures provided to young people. The MCH Social Worker provides community and school outreach activities on self-esteem, rape counseling and prevention as well as offering one on one counseling to teenagers.

The recently established women's clinic held after working hours (4-8 p.m.) providing confidential family planning counseling also contributes to this effort to decrease teen age pregnancy. Teenagers are able to use this clinic during conveniently established hours in order to seek guidance and counseling regarding sexuality, sexually transmitted diseases, and family planning.

American Samoa is a Territory where religion and cultural influences are strongly observed. Family structure and ties have a strong influence on youth behaviors guiding them in their social activities, thus helping to reduce the incidence of teen pregnancies. Failure to meet the target for this performance measure indicates that increased Title V activities will need to be focused on decreasing teen pregnancy.

N7 Percent of third grade children who have received protective sealants on at least one molar tooth.

In 1999, sealants continued to be provided for children in the first grade with follow up assessments in the fourth and eighth grades. The LBJ Dental Program did not provide sealants for third grade children as recommended. This change in protocols has successfully taken place in 2000. The Department of Health collaborates with the LBJ Dental Program by providing sealants and toothbrushes. The MCH School Health Program provides outreach and a screening clinic to all elementary schools and preschools.

Strong relations between MCH and the dental clinic have been formed. In 2000, third graders began to be targeted by provision of sealants to this age group.

The School Health Team continues to provide students with health talks on proper brushing and education on the effects of making poor nutritional choices. Each child is given an appointment for a dental visit and a pamphlet on tooth care to take home to their parents. The MCH nutrition program conducted two television programs on eating the proper foods in order to prevent dental problems on a weekly health-related television program.

N8 The rate of deaths to children aged 1-14 caused by motor vehicle crashes per 100,000 children

This objective was not met. The objective for this measure was set at 1.6 as compared to the indicator for 1999, which was 7.5 per 100,000.

Title V continues to focus efforts towards reducing this rate. The MCH Program plays an advocacy role in assisting the Department of Education in reviewing their health curriculum for elementary schools, which includes motor vehicle safety. The MCH Health Educator is a part of the discharge planning committee that developed and implemented a discharge health education curriculum for mothers in the maternity ward so that all mothers receive health education on issues such as breastfeeding, umbilical cord care and the purchasing of car seats for children.

Uniform health education modules have been developed by the Quality Assurance Coordinator and the MCH Consultant. The series of health education modules includes the appropriate use of car seats. Each health education module has age-appropriate information concerning proper car seat use, safety considerations concerning car seat use and referrals to the Department of Motor Vehicles for additional information concerning age-and weight appropriate car seat specifications. These health education modules are currently being utilized at the dispensary level.

The situation in American Samoa, a small island Territory, is different from that in the United States mainland with regard to motor vehicle accidents. As on the mainland US, legislation requires the use of seat belts and car seats for children. The speed limit on the island, however is 25 miles per hour. Legislation further requires passengers on the backs of pickup trucks to sit within the sides and not on the edges. Recent legislation (enacted within the past few months) prohibits children under the age of 12 from riding in the back of a pick-up truck without an accompanying adult. It is further noted that the Department of Public Safety has significantly increased the frequency of roadblocks enforcing the use of safety measures for adults and children including use of car seats and seat belts.

N9 Percent of mothers who breastfeed their infants at hospital discharge

The target of 81% of mothers who breastfeed at hospital discharge was not met in 1999.

The following Title V (factors) activities contributed to this :

(1) MCH staff employed under Title V promotes breastfeeding at every opportunity of contact with pregnant women and new mothers. This includes prenatal clinics, WB clinics, Family Planning, outreach visits, and WIC encounters.

(2) In 1998, MCH staff established a Breastfeeding Committee, which meets regularly in order to discuss and implement activities intended to increase breastfeeding rates. This committee has not met regularly during 1999 but was able to hold a week-long health education promotion which focused on breastfeeding. **A closer working relationship needs to be fostered with LBJ Administration in order to facilitate policy change in the Nursery and Maternity wards.** The Breastfeeding Committee advocates that newborns are immediately put to the breast right after delivery. This has not, however, resulted in a consistent policy change. Future policy-level activities must occur in order to facilitate this change. Discharge education on breastfeeding is stressed as being highly important., the rooming-in policy allows new mothers to have full access to their newborns, and breast-feeding counseling is provided on the first postpartum day.

N10 Not applicable to American Samoa

N11 Percent of Children with Special Health Care Needs (CSHCN) in the State CSHCN program with a source of insurance for primary and specialty care.

The target was met in 1999. One hundred percent of CSN children have a source of insurance for primary and specialty care.

The American Samoa Government is unique in that all health services, primary and specialty care, are available to all residents including special health care for children with handicapping conditions free of charge. Title XIX funds are provided to the Territory in the form of a capitated lump sum. This goes towards the overall provision of health care services in the Territory. Consequently 100% of CSHCN in the program have a source of insurance for primary and specialty care.

Title V staff in American Samoa continues to monitor this situation and assists families in accessing the health services which are available to them.

N12 Percent of children without health insurance.

This target was met in 1999. There are no children in American Samoa without health insurance. Again, this is due to the unique situation in American Samoa whereby all residents are provided free health care.

The American Samoa Government Code states that all health services, primary and specialty care, are available to all residents including specialty health care for children free of charge. Although most CSHCN do not have an individual or family policy as such, they are covered under this blanket law and consequently there are NO children

(0%) who do not have health insurance. Title V staff assists families in accessing the services they require.

Additionally, Medicaid funds are distributed to LBJ Hospital Authority in a lump sum. The Health Department is provided medical supplies and utilities form the Medicaid funding. Recently, Children's Health Insurance Initiative (CHIP) funding has been made available to the Territory. The MCH Coordinator is a member of the CHIP Planning Committee.

N13 Percent of potentially Medicaid eligible children who have received a service paid by the Medicaid Program.

The target for this performance measure was fully met in 1999. One hundred percent of potentially Medicaid eligible children received a service paid by the Medicaid program in 1999.

The American Samoa Government Code requires that all health services, primary and specialty care, are available to all residents free of charge. The health services provided free are financed by local American Samoa Government revenue and a capitated amount of Medicaid funds which are received by the Territory in a lump sum. These funds contribute to the overall provision of health care services in the Territory. Due to this unique situation, all potentially eligible Medicaid children receive a service paid by the Medicaid Program.

N14 The degree to which the State assures family participation in program and policy activities in the State CSHCN program.

The target for this objective was not met in 1999. The Territorial CSHCN Program was able, however, to maintain the level of participation set in the 1998 application. The objective to increase to a level of 4 out of 18 was not realized in 1999. The Program scored a 3 out of 18 on this measure. Title V plans to address this with specific activities outlined in the annual plan.

Title V was able to maintain the level of involvement from 1998 by encouraging families to participate in the review and participation in inservice training sessions.

In American Samoa, family participation in CSHCN programs has been low– the score continues to be 3/18. As in 1998, family participation for this year included an invitation to review the Developmental Disability Council Annual Plan and the MCH block grant application. Attendance at these events tends to be low.

There was also participation of families in inservice training of CSHCN staff and providers. Some families accompanied their children to the inservice programs and participated in discussions. In the future it may be possible to involve family members more with advisory committees and inservice training. Every effort is made by Title V

staff to encourage family participation in program and policy activities. These efforts will continue in the future.

N15 Percent of Very Low Birth Weight live births

The target of this Performance was met in 1999. The baseline percentage of very low birth weight infants was established at .5 percent. As evidenced by the indicator, this target was met in 1999. As with this Performance measure, American Samoa experiences a small annual number of events. In the future, it will be necessary to develop data collection and analysis policies and procedures aimed at improving the validity of data for performance measures such as these. Problems with "small numbers" such as in this case will have to be addressed, possibly necessitating the need for using a 3 or 5 year moving average. The new focus of SSDI will afford Title V an opportunity to improve data items such as these during the next year.

Title V plays a role in the very low occurrence of very low birth weight. Health education efforts concerning the benefits of early and consistent prenatal care, proper nutrition during pregnancy, appropriate weight gain, etc. impact the low incidence of very low birth weight. Further, Title V has contributed to this accomplishment through the provision of prenatal care by nurse practitioners.

The importance of this performance measure to American Samoa is worthy of discussion. The average birth weight of Samoan babies is higher than in the US mainland. Birth weights for gestational period is higher. Therefore, there are very few very low birth weight babies where less than 1500 grams is used as the definition of very low birth weight. Where birth weights are generally higher in American Samoa, this may not be the best indicator of a baby who is in sub-optimal health.

N16 The rate (per 100,000) of suicide deaths among youths aged 15-19.

This target was fully met in 1999. Baseline data for this performance measure for 1999 was 11 per 100,000. The actual indicator for 1999 was .5.

American Samoa experiences a small annual number of events of teen suicide deaths. In the future, it will be necessary to develop data collection and analysis policies and procedures aimed at improving the validity of data for performance measures such as these. Problems with "small numbers" such as in this case will have to be addressed, possibly necessitating the need for using a 3 or 5 year moving average. The new focus of SSDI will afford Title V an opportunity to improve data items such as these during the next year.

Title V played a role in this achievement in 1997. The school health team addresses subjects such as self-esteem and appropriate decision making with children through the eighth grade. It is further noted that an examination of *suicide attempts* (although this number would naturally reflect under-reporting) would provide a more meaningful glimpse into the suicide-related occurrences in this population.

N17 Not applicable to American Samoa

N18 Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

This performance measure was not met in 1999. An examination of first trimester prenatal care rates show that 14% of deliveries occurred to women who accessed prenatal care in the first trimester. The objective for 1999 was set at 21%. As with other performance measures, American Samoa Title V is experiencing difficulty in consistency of data collection methods. Data reported for this measure (14%) was derived from a random survey of hospital charts and is believed to be a reliable number. Prenatal care rates in Samoa are alarming with 29% initiating prenatal care in the second trimester, 51% in the THIRD trimester and 6% who do not access prenatal care at all.

Inconsistencies in data collection methods may account for the wide variations in data reported from year to year. The next few years of SSDI will address problems such as this in all performance measures, outcome measures and health status indicators.

First trimester prenatal care rates are very low in American Samoa. The MCH Program has put efforts into determining obstacles to early initiation of prenatal care. Focus groups and various survey methods have been used to illuminate this subject. Many women report that they do not have the time to travel to appointments with other small children. Childcare and travel time tend to be common obstacles to early initiation of prenatal care.

As a result, Title V has continued to offer prenatal care in the village dispensaries so that women do not have to travel in to the main hospital for their prenatal care. Women are given written appointment cards for prenatal care visits. Reminder calls are made to the homes of women who miss prenatal appointments. Other strategies have been explored and Title V personnel are keenly interested in ways to increase the percent of infants born to women receiving prenatal care beginning in the first trimester.

Health education is conducted at the time that a couple seeks a marriage license. The MCH Social Worker counsels couples on the importance of prenatal care and appropriate birth spacing. Appropriate referrals are made to the Family Planning Clinic. Early initiation of prenatal care is frequently addressed on health-related television programs.

STATE PERFORMANCE MEASURES

S1: Percent of mothers in the WIC Program who exclusively breastfeed their infants at 6 months of age

The attainment for this performance measure in 1999 was 12.7%. As such, the objective was met for this reporting period.

Title V continues to work towards this objective through collaboration with WIC and coordination of activities through shared personnel. Title V staff work on-site at the WIC office through a Memorandum of Understanding (MOU). A Public Health Nurse Practitioner and her staff members provide nutritional counseling and breastfeeding support. Breastfeeding is actively encouraged at each point of contact with pregnant women.

Counseling on a one to one basis is provided to WIC clients who breastfeed, including during the prenatal period if they enter program at that time. Bonus WIC vouchers are provided to mothers who breastfeed. The mothers come in to receive vouchers and are re-certified for eligibility. Clients receive counseling at each of these encounters. Mothers are given breast pumps (supplied by WIC) when needed, and are provided with counseling on breastfeeding on a walk-in basis. Referrals are made for women with problems (OB Clinic, P.H. Nutrition, Medical or specialty clinics, etc). The MCH Health Educator also provides breastfeeding health education activities at Public Health Clinics.

In 1998, the Breastfeeding Committee was established by the MCH/WIC Nurse Practitioner. The Committee is comprised of representatives from Public Health, LBJ Tropical Medical Center (Nursery, Labor and Delivery, Maternity wards) and LBJ Nursing leadership as well as community members. This Committee is well established and meets regularly to discuss new activities aimed at increasing breastfeeding rates. In 1999, a "Breastfeeding Promotion" week was held during which time, breastfeeding committee and greater Health Department staff promoted breastfeeding through media activities. Some of these new initiatives will be adopted in 2000 and are described in the annual plan.

S2 To decrease the rates of dental disease through a comprehensive preventive dental health program (Education sessions, toothbrush distribution and fluoride and sealants)

This performance measure was fully met in 1999. A scale was designed this year in order to monitor program implementation. The program has met a target of 5 out of a possible score of 12.

The Some baseline data has been collected on the prevalence of dental caries in the Territory. A total of 5,982 health screenings were conducted in schools and revealed that 5,085 or 85% showed evidence of dental caries. All children with dental caries were referred to either the ECE center for follow-up or the individual child's elementary school where the Dental Services provide a mobile dental clinic on an as-needed basis.

The ECE has provided improved office space for this on-site clinic and the LBJ Dental Clinic provides appropriate staffing of a dentist and a dental assistant. Equally, a dentist and dental assistant staff the mobile unit.

Of those 5,085 who were referred, the Dental Clinic data shows that 2,195 children actually followed through by accessing these dental services.

This program is being developed and more fully implemented in 1999.
Project monitoring showed that the following activities were conducted during 1999:

- Individualized health education information is given to each child upon access to the dental services program.
- Toothbrushes and fluoride rinse is provided to all children
- Pre-testing and post-testing of children for their knowledge of basic dental health issues
- Results of dental caries health screenings (this is the outcome which is expected to decrease over time)
- Referrals to the dental clinic for children with dental caries.

Efforts are being made to establish a successful collaborative relationship between MCH and Dental Health Services. This has been done through a cost sharing of sealants and purchasing of tools for the dental outreach program. The MCH Coordinator and the Chief of Dental Health Services are both members of the CHIP Committee. The CHIP Committee is now in the process of approving increased funding levels for Dental Health Services to expand its' outreach program. MCH fully supports Dental Services efforts to increase preventive activities in schools.

The Chief of Dental Health Services has agreed to focus on 3rd grade students in satisfaction of this MCH performance measure.

S3 Nutrition education on breastfeeding for pregnant women attending prenatal care clinics

The target for this performance measure was not met in 1999. Data shows that 91% of women who attend prenatal clinics received at least one nutrition education and counseling. The objective for this year was set at 97%. Transportation and lack of staffing are cited as the most common obstacles to achieving the target for this measure.

These nutritional counseling sessions were provided on an individual basis in three health clinics on the island. Two of these clinics are village dispensaries and the third is the central clinic located at LBJ Tropical Medical Center. Prenatal and post partum care is offered at all three of these locations. During these counseling sessions, one staff member from the nutrition program counsels women on initiation and maintenance of breastfeeding, the importance of a well-balanced diet (5-a-day) that promotes better

health and breastfeeding success and activities that will help promote lactation. Moreover, they promoted lifestyle practices that enabled successful breastfeeding.

S4 Percent of breastfeeding women attending post partum clinics who receive at least one health education session.

The objective for this measure was 34% and the achievement was 89% of post partum women who received at least one health education session. The target for this measure was exceeded.

Nutritional counseling sessions are provided on an individual basis in three health clinics on the island. Two of these clinics are village dispensaries and the third is the central clinic located at LBJ Tropical Medical Center. Post partum care is offered at all three of these locations. During these counseling sessions, one staff member from the nutrition program counsels women on initiation and maintenance of breastfeeding, well-balanced diet (5-a-day) that promote better health and breastfeeding success and activities that will help promote lactation. The percentage of women receiving this educational session is low due to the relatively low numbers of women who return to the clinic for post partum care.

S5 Percent of pregnant women screened for Hepatitis B.

The target for this performance measure was not met in 1999. The target for 1999 was 91% of pregnant women screened for Hepatitis B. The percentage achieved for this performance measure in 1999 was 66%. This was due to circumstances beyond the control of Title V and immunization programs.

The equipment that is used for Hepatitis B testing was not in service for a period of over 7 months. Lab reagents for Hepatitis B testing were not available for a period of several months. The technician who services the machine resides in Australia and is only available to travel to Samoa during certain scheduled times. The reagents were not available because there was difficulty in getting outstanding bills paid to the vendor.

Title V was involved in the limited successes of this performance measure during the times that testing was possible during 1998. A collaborative relationship exists between the hospital and Public Health towards the common goal of referring all prenatal women to the Hepatitis B program for screening as a normal component of prenatal care.

Collaboration between Title V, The Immunization program and the Clinic Supervisors continues in an effort to refer all prenatal women to the Hepatitis B program as a standard component of prenatal care.

S6 Percent of susceptible pregnant women vaccinated.

The target for this measure was not achieved in 1999. The actual achievement for 1999 on this performance measure was 47% while the objective was set at 51%.

The Hepatitis B program experienced some overall difficulties in 1999 where the testing machine was in a state of disrepair for an extended period of time. Program staff report that women who are pregnant are reluctant to be vaccinated out of fear that the pregnancy could be jeopardized. Health education efforts will continue to dispel this myth and the collaborative efforts of Public Health, LBJ Tropical Medical Center, Title V staff and the Immunization Program will continue as well.

S7 Percent of 15 month old children vaccinated.

The target for this performance measure was not met in 1999. Sixty-eight percent of 15-month-old children were vaccinated while the target was set at 73%. All infants receive hepatitis B immunization at birth.

Follow-up appointments are given for the second shot of the series at 2 months of age. The 3rd vaccination of the series takes place at 12 months in the health center closest to the parent's home. Infants of carrier mothers receive 3rd immunization at 6 months rather than 12 months. Every child should have completed the series by 12 months of age.

Title V provides nursing support and guidance, inservice training and conducts health education activities towards the accomplishment of this objective.

S8 Percent of 6 year olds who have completed immunizations

The target was met and surpassed in 1999 for this performance measure. In 1999, 89.8% of 6 year olds had completed the required immunization series. Title V contributed to this accomplishment through health education activities, assessments made by the school health program and a coordination of efforts with the MCH pediatricians. The MCH pediatricians assess children's overall health status prior to the immunization in cases of questionable health. They also provided inservice training for staff members involved in the Immunization Program.

Each of the Public Health dispensaries is open daily to provide immunizations for all ages. Supervisors or managers of each dispensary have a tracking system that helps them track children who are not fully immunized. Further, if an appointment is missed a telephone reminder is initiated. After one month, if the child still has not come into the dispensary, a home visit occurs.

Dispensary nurses further improve immunization rates by conducting village clinics during immunization week. A media campaign is implemented during immunization

week prior to the beginning of the school year in order to increase immunization rates. The School Health program screens immunization cards during school visits. If a child is found with incomplete immunizations then a referral is made to the appropriate Dispensary.

It is required by law that all children should be fully immunized before entering school. The MCH Immunization program continues to assist the Department of Education in order to enforce this law. Before entering preschool, the child should have a round stamp signed by Public Health to notify the school or the admissions office this child is fully immunized for his/her age. A rectangular stamp identifies this child is fully immunized and should be allowed to enter elementary school. The Department of Education admissions office or the individual school will refer the student to Public Health. He or she will not be allowed to enter school without a verified signed stamp.

In 1999, Public Health Dispensaries also maintained their policy of allowing walk-in visits for immunization purposes.

S9 A multimedia community awareness program to improve the access to and utilization of MCH services.

The target for this performance measure was met in 1999. A simple scale is included in form 11 in order to measure progress towards this performance measure. For this year, the performance measure has reached a completion level of 7 out of a possible score of 18. Radio spots have been developed, newspapers have been contacted, the individual programs have begun writing articles to be included in the island's newspapers and the weekly health related television show has begun to air programming related to MCH services.

S10 Awareness and education program for Children with Special Health Care Needs (CSHCN) care takers and teachers.

The target set in 1999 for this performance measure was met. A simple scale is attached which describes the program components. The program achieved a possible score of 4 out of a total score of 12. This accomplishment was achieved despite many obstacles experienced by Title V staff in the past year.

Several key staff members of the CSN program were unavailable for an extended period of time 1999. The MCH/CSN Case Manager spent 5 months off-island New Zealand for a medical emergency. In addition 2 other key CSN Team members terminated their contracts in order to return to New Zealand. This abrupt break in continuity of program staffing contributed to the inability to meet this performance measure target.

Planning and development stages have included identifying groups targeted for this purpose. These groups are: Teachers including Special Education Teachers, Mainstream Teachers, and ECE/HeadStart Teachers; School Bus and taxi drivers;

Respite Care Staff; Pediatric Clinic Nurses; Dispensary Nurses and a selection of Parents. Also included in this phase is the development of a questionnaire in order to establish baseline information on the level of awareness of CSHCN issues among these groups. Activities such as positioning and handling, hygiene, safety, dental care, appropriate exercises and stimulation will be included. The results of this baseline data will provide the basis for an educational program.

The FY 2000 Needs Assessment process resulted in a re-focus of Title V efforts. Seven new performance measures have been chosen for the new 5-year Grant cycle and will replace the 10 state negotiated performance measures listed above. The new State (Territorial) Performance Measures are listed as follows:

- To increase the percent of women with a live birth who have received adequate prenatal care as determined by the Kotelchuk Index.
- To increase the percent of children with completed immunization among the children with special needs who are known to the CSN Program.
- To increase the percent of children with special needs who have received all of the recommended services within 12 months of the date of recommendation.
- To decrease the percent of 2, 3, and 4 year old children who are seen in the MCH Well Child Clinic who have dental caries on examination.
- To increase the percent of 6 month old infants who attend the Well Baby Clinic at 6 months of age who are exclusively breastfeeding.
- To increase the percent of children with special needs who have received an annual reevaluation by an interdisciplinary team.
- To decrease the percent of adolescents in Grades 9-12 who report smoking cigarettes within the past 30 days.

2.5 Progress on Outcome Measures

The presence of Title V in American Samoa serves to positively impact on the established Outcome Measures. While all Title V programs concentrate efforts towards improved health among the maternal and child population, some performance measures are more strongly linked to improvements in outcome measures.

- High breastfeeding rates (71%) at hospital discharge positively impacts infant mortality and morbidity. Title V efforts play a significant role in this accomplishment.
- High immunization rates (86%) decreases child/infant mortality due to vaccine preventable diseases. Title V, in collaboration with the Immunization Program contributes greatly to this accomplishment.
- 100% eligibility for Medicaid & accessibility to medical home ensures early treatment of childhood complications (injuries and illnesses) and, therefore, serves to positively impact the infant mortality and child death rates.
- The degree to which CSHCN program pays for specialty and subspecialty services is high in American Samoa. This results in increased child survival rates in the 1-14 year old population.

- At least 1 nutrition counseling session during the prenatal and post partum period results in better pregnancy outcomes and can influence breastfeeding success and duration. Where accomplishments in this performance measure leave room for improvement, Title V could concentrate efforts in this area in order to positively impact the infant mortality rate.
- Low rates of initiation to early prenatal care (14%) in American Samoa appear to be correlated with a high infant mortality rate. Prenatal care rates in Samoa are alarming with 29% initiating prenatal care in the second trimester, 51% in the THIRD trimester and 6% who do not access prenatal care at all.
- Title V strategies to increase rates of access to early prenatal care may be those strategies which are most likely to decrease the infant mortality rate.
- A very low teen birth rate (25 per 1,000) in American Samoa positively impacts the rate of very low birth weight babies and lower infant mortality rate.
- Low very percentage of low birth weight results in increased infant survival rates, and decreased complications. In American Samoa, however, percentage of very low birth weight is probably not likely to have a positive impact on the infant mortality rates due to the definition of the term “very low birth weight.” This is an issue, which is outside the control of Title V as “very low birth weight “ is a term, which is nationally defined as less than 1500 grams. While Samoans have larger (heavier) babies for gestational age, there is a relatively high infant mortality rate while the rate of very low birth weight is extremely low.
- Very low car accident death rates (7.5 per 100,000) and teen suicide rates in American Samoa have a positive impact on 1-14 year old child mortality.

III. REQUIREMENTS FOR APPLICATION

3.1 Needs Assessment of the Maternal and Child Health Population

3.1.1 Needs Assessment Process

The development of a Five-Year Needs Assessment of the Maternal and Child Health population involved the active participation of all Title V staff and occurred throughout FY 2000. All Title V staff participated in the Pacific Island's Distance Learning Project, which represented a coordinated effort between the Bureau of Maternal and Child Health (MCHB) and the MCH Training Program within the School of Public Health (University of Hawaii). All Title V staff fully participated in the process of choosing various health status indicators in order to broaden the discussion of the overall health status of each of the three distinct population groups targeted by Title V.

The MCH Consultant has played a valuable role in guiding the MCH staff though the beginning stages of deciding which indicators best describe the respective population groups. All MCH staff members convened in a workshop format in order to choose an exhaustive list of health status and health service indicators pertinent to MCH population overall. Program staff members who work closely with each of the three sub-populations under Title V broke into small working groups in order to choose the indicators which are most relevant to the particular situation in Samoa.

During the course of this workshop, the following key questions were used to facilitate a discussion of each proposed indicator:

- Is it an important indicator for describing the needs of this population?
- Is the data available?
- Who will collect the data?
- How will the data be collected?
- How will the data be analyzed?

Pacific Island's Distance Learning Project

Beginning in August of 1999, a series of learning modules were made available on CD and posted on the Internet as a guide to conducting the Needs Assessment of the MCH population. The modules included topics such as: selection of indicators, data sources, qualitative methods, quantitative methods, data analysis, etc. The task of conducting a comprehensive Five-Year Need Assessment in a Pacific Territory without some of the basic skills required for successfully completing this task is overwhelming. Few individuals within the Department of Health have advanced training in Public Health. In past years, Needs Assessments were conducted by sole individuals working with the Department on contract or by off-island consultants working in the Territory. However, the technical assistance provided by the MCH Consultant as well as the interactive, hands-on experience provided through the Pacific Island's Distance Learning Project provided the necessary assistance for conducting a comprehensive Needs

Assessment that includes the population of pregnant women and infants, children and CSHCN.

Methodology

Since the initiation of the new performance-based Title V guidelines introduced by MCHB in 1998, the Title V staff in American Samoa has been organized into 3 distinct work groups: pregnant mothers and infants, children and adolescents and children with special health care needs. Each of these three work groups provides the input for the development of the Annual Report, Annual Plan, and the Needs Assessment. Work group members collaborate in the discussion and analysis of data, present compelling information related to their respective areas of expertise, present specific knowledge gained from their respective roles in the delivery of services to the MCH population and interface with members of each of the other two working groups in an effort to prioritize health status problems and gaps in service delivery.

Key steps in "cycling" from the development of the Title V Needs Assessment through the identification of priority needs, establishing Territorial performance measures, setting annual targets for national and Territorial performance measures and developing annual plans to meet targets are outlined below:

- In order to begin the Title V Needs Assessment process, the entire Title V staff met as a large group in order to arrive at a comprehensive list of all health status indicators and, later, health service indicators relevant to the MCH population in American Samoa. This comprehensive list of data elements took into consideration each of the 4 levels of the pyramid.
- Each data element was, then, assessed according to the following criteria:
  - Availability of data
  - Usefulness of data
  - Integrity of data
  - Data collection method
  - Data analysis method
- Many data collection problems were identified. Health status and health service delivery data is still collected in a haphazard fashion in American Samoa. Through the efforts of SSDI, a unified system of data collection is being developed.
- In March of 2000, the MCHB revealed the standard data elements which every State and Territory would be required to report on along with a number of developmental data elements. This provided an opportunity for Title V staff to focus efforts on the collection and analysis of data required by the MCHB as well as the developmental data elements.
- **Data collection limitations:** Data which is required in order to calculate the Kotelchuck index- mother s age, month when first prenatal care

began, the number of prenatal care visits, and the gestational age of the infant at birth, are all found on the standard birth certificate. American Samoa, however, does not use the standard birth certificate. Data collection methods required in order to satisfy this data requirement necessitate a manual collection of data from logbooks written by the nurses in the clinic. Further, the overall lack of an automated data collection system requires that data is collected from charts and other forms which are not "clean" sources of data. As a result, the integrity of the data is sometimes suspect. Discussions regarding the adoption of the U.S. standard Birth Certificate have taken place and the Vital Statistics Committee will, possibly recommend this change to the Governor. This change enable the MCH program to measure the Kotelchuk Index, but will also allow a much better opportunity for the MCH program to assess perinatal health care for mothers and infants.

- The Title V staff as a whole, examined all data presented and arrived at a list of 7 priority needs. An objective method of scoring health status problems, the Hanlon Method, was used to attach a score to each health status problem revealed. . The Hanlon Method examines the list of problems from three different aspects as the priority setting method. The three components of the Hanlon Method are: Component A - The size or magnitude of the problem, Component B - The seriousness of the problem, and Component C - The effectiveness of available interventions.
- The use of this objective method of priority setting enabled the Title V staff and leadership to arrive at the 7 priority areas for the Territory.
- Subsequently, a performance measure was written for each priority area.
- Targets were then set after in-depth discussions amongst staff of the indicators for each measure and a clear estimation of possible progress that could potentially be made, taking into consideration, any obstacles to progress.
- Each group: women and infants, children and adolescents and CSHCN produced their own work plans for the coming year and submitted them to the Title V main office. Each plan also contained a budget.
- The MCH Coordinator was responsible for making all final budgetary decisions

Collaboration

The Departments and agencies which collaborated on the development of the Needs Assessment are outlined below:

- Department of Education - provided data for data elements including YRBS data.
- LBJ Tropical Medical Center-
  - Dental Services Division - provided data and other information regarding the dental health needs and services of the MCH population.
- Vital Statistics - assisted in providing data for needs assessment as well as outcome measures.

- Department of Commerce - provided data and overall statistical information for the general overview of the Territory as well as some demographic data.
- A committee comprised of a number of government department representatives including a representative of the Community College reviewed the Needs Assessment and their input was solicited.
- The Needs Assessment, Annual report and Annual Plan was made available in the Public Health conference room for public review and comment.

Strengths and weaknesses

- The process used by Title V in American Samoa is very time consuming and demanding of staff time and efforts. The process used by the program, however, allows for the greatest level of staff participation. As a result, all staff members feel a greater level of involvement and commitment to the programs.

3.1.2 Needs Assessment Content

3.1.2.1 Overview of the Maternal and Child Health Population Status

The American Samoa Title V leadership staff is often exposed to those involved with Title V programs at the National level. Meetings (AMCHP, MCH Leadership Meeting etc.) provide an opportunity to learn about the National emphasis of Title V, goals, objectives, new initiatives etc. While it is recognized and appreciated that Title V represents programs of *national* emphases, it can be discouraging to leadership and staff alike to use US National data in order to provide comparisons of data sets. As a small island territory which is geographically isolated form the US and a very unique and strong cultural heritage, American Samoa is, in many ways, very different from the US mainland. As such, it is found to be more useful to Title V program leadership to compare health status indicators and core outcome measures against previous years' data (as opposed to *Health People 2010*) whenever possible. For the purposes of this Needs Assessment, comparisons are, therefore, made against data from the Territory from previous years, and on the regional level with data from other Pacific Island jurisdictions.

Priority Health Problems

Each of the three work groups: Pregnant women and infants, Children and adolescents, and Children with special health care needs, met a number of times throughout the development of the 5-Year Needs Assessment. Each group met with the intention of discussing the overall health status of the populations with which

they work, suggesting possible health status indicators appropriate for each group, providing data for the National Core Health Status Indicators. Each group met with the intention determining additional health status indicators, specific to American Samoa, which would expand the level of assessment beyond that of the National Core Indicators. The results of the work groups are presented below and are described as **priority health problems.**

Pregnant women, mothers and infants:

- **To increase the number of infants born to women receiving adequate prenatal care according to the Kotelchuk Index.** The data related to this need area shows that a random survey and review of 136 prenatal charts for 1999 showed that only 22% of the women received adequate prenatal care and 78% did not receive adequate care; other reviews of prenatal charts for 1999 showed that only 14% of the women initiated care in the first trimester; (29% initiated care in the second trimester, 51% initiated care in the third trimester and 6% received no care at all) The 1999 IMR is 12.7/1000 live births and there is an increasing trend over the past several years that is believed to be associated with the lack of adequate prenatal care.

  Prenatal care rates have been consistently been low in the Territory of American Samoa. Inconsistencies in data collection methods make it difficult to compare data over time. However, it is clear that the rate of initiation to early prenatal care is *decreasing.* Some qualitative research has been conducted in this area in past years and the following barriers are cited: 1. Lack of transportation, poor roads 2. Other childcare or work obligations 3. Perception that prenatal care is unimportant 4. Traditional beliefs that any intervention of "modern medicine" is unwise and potentially threatening to the pregnancy. 5. Some women opt for care provided by a "traditional healer". Clearly this list of barriers hints at the accessibility and perceived acceptability of prenatal care in the population of women in American Samoa.
  The seriousness of this problem is underscored by a comparison of data relevant to the early initiation of prenatal care in the other Pacific Island jurisdictions. In 1996, the Federated States of Micronesia reported that 11% of infants are born to women receiving care in the first trimester. This is the closest comparison to the data derived from the Needs Assessment data obtained for American Samoa. Other island jurisdictions show higher rates of early prenatal care: Marshall Islands-25%, Palau-35% and Guam, perhaps the most "modernized" of the Pacific jurisdictions, 66%.

- **To increase the number of women breastfeeding at 6 months of age.** Current data shows that only 71% of the women are documented as breastfeeding at hospital discharge, whereas the target is 81%; the number of women breastfeeding their infants significantly decreases after hospital discharge and only 12.5% of the infants are reported to be exclusively breastfeeding at 6 months of age.

It was hoped as well as assumed that the Supplemental Feeding Program for Women, Infants and Children (WIC) which was extended to include the Territory in 1996, would assist Public Health in the efforts to encourage women to breastfeed and subsequently, increase rates of breastfeeding. In American Samoa, however, the exact opposite appears to be true. It is believed that the following factors have contributed to low breastfeeding rates in the Territory: 1. The WIC "package" automatically gives formula to women in the program when their babies reach 6 months. (many families in the "village setting" share food and benefits, including formula.) 2. The WIC "package" consists of mainly foods that are not generally consumed in American Samoa (dried beans etc) No efforts have been made towards adapting the food package to include local, more appropriate foods.

Policy changes are essential to broadening the Department's capacity to influence increases in breastfeeding rates. The Department must work closely with WIC as well as with the Hospital administration in order to make both environments more "baby friendly." Policy changes will be required in order to implement changes in delivery room and nursery protocols. Currently, babies are not put to breast immediately after birth and are routinely brought to their mothers on the maternity ward with a bottle of formula in the bassinet.

A regional comparison of breastfeeding rates at hospital discharge is very interesting with a very wide range of data reported. Some Pacific jurisdictions offer a rate of 100% (Palau and FSM) while Palau is close to this at 96% (and American Samoa currently at 70%. Guam, interestingly, reports 5% of women breastfeeding at hospital discharge.

- **To improve the nutritional status of pregnant women during their pregnancy**. There is a consensus among the MCH staff that a large proportion of women in prenatal care clinics have low hemoglobin - however, there is no data to substantiate this conclusion.

  The professional staff members of this work group felt that their collective professional opinions on this issue, while anecdotal, were strong enough to present this as one of the *priority health problems* for the population of women, mothers and infants.

  There is also no available data for a regional comparison for this priority area.

Children and Adolescents:

- **To decrease the DMF rate among children.** Past surveys of the ECE population showed that over 85% of the children had serious dental disease. There have not been any recent surveys conducted; however, the consensus

of the MCH staff is that dental disease among children continues to be a major public health problem.

Lack of sealants as a surrogate indicator for poor dental health shows a wide range of data reported by the Pacific jurisdictions. The FSM reports only 2.6% of third graders had received sealants while Palau reports a very high percentage at 81% .

The work group for children and adolescents chose the overall rate of DMF to be of a high concern in this population and has isolated it as a *priority health problem.*

- **To decrease iron deficiency anemia among children (WIC, WBC).** Current data from the Well Baby Clinics show that 32% of the infants tested had low hemoglobin.

  The work group for children and adolescents chose the overall rate of low hemoglobin to be of a high concern in this population and has isolated it as a *priority health problem.*

- **To decrease the percent of students drinking alcohol.** The 1999 Youth Risk Behavioral Survey (YRBS) showed that 32% of the students had at least one drink of alcohol on one or more of the last 30 days; whereas 56% of the students had at least one drink of alcohol on one or more days during their life. The 1997 survey showed that 54% of the students had ever had alcohol.

  The work group for children and adolescents chose a reduction in the percentage of students drinking alcohol to be of a high concern for this population and has isolated it as a *priority health problem.*

  Interestingly, the State of Hawaii chose a state negotiated performance measure on alcohol consumption in the teen population as well, reporting that 25% of teenagers from 12-15 reported alcohol use within the past 30 days as reported on the YRBS.

- **To decrease the percent of students smoking tobacco.** The 1999 Youth Risk Behavioral Survey showed that 73% of the students reported having had tried smoking and 41% of the students reported smoking cigarettes on one or more the past 30 days.

  The work group for children and adolescents found this information compelling enough to isolate this as a *priority health need* for this population.

- **To increase the percent of sexually active adolescents using condoms.** The 1999 Youth Risk Behavioral Survey showed that 40% of the students reported having had sexual intercourse; whereas in 1997, 37% reported

sexual activity. In 1999, 31% of the male students reported using a condom during their last sexual intercourse.

The work group for children and adolescents found this information compelling enough to isolate this as a *priority health need* for this population.

Children with Special Health Care Needs

- **To increase the completed immunization rate among children with special needs.** Current data shows that of the 135 children in the CSN data base, 40% have completed immunization.

  The low percentage of the CSHCN population with completed immunizations, indicates that this is a problem that needs addressing. While the CSN population is a relatively "captive" population and known to the program on an individual basis, it was believed that this percentage should be significantly higher.

  Many believe that in the CSHCN child, current immunization status is not an important factor because of the belief that the child is homebound nearly 100% percent of the time. In additions to this belief, there is a cultural perception that the child with a disabling or handicapping condition reflects back on some previous wrongdoing on the part of the family. As a result of these factors, many CSHCN children are kept from the public's eye to prevent shame on the family.

  Recently, however, due to:
  1. mainstreaming placement in schools
  2. arrival of federally funded programs such as WIC and food stamps

  The numbers of CSHCN children on the island has been illuminated through the eligibility process for these programs.

  The work group for CSHCN found this information compelling enough to isolate this as a *priority health need* for this population.

- **To improve the health function of children with special needs by assuring that services recommended on the evaluation are provided in a timely manner.**

  This priority health problem area was chosen because of the critical need of this population to receive all recommended services as defined by their individual service plan. Only 7 % CSHCN are currently receiving all recommended services as outlines in their individual service plans.

The work group for CSHCN determined that this should be viewed as a main priority health problem for this population.

- **To increase the percent of children with special needs who have an annual re-evaluation by an interdisciplinary team.** Of the 135 children in the CSN data base, 17% of the children currently have an annual re-evaluation completed by an interdisciplinary team.

  The work group for CSHCN determined that this should be viewed as a main priority health problem for this population.

- **To improve the nutritional status of children with special needs.**

  Using the diet recall and growth (height/weight) chart, it has been determined that 60% of CSHCN in American Samoa are at the 25th percentile or below. Growth charts used by the program were not specifically designed for evaluating children with disabling conditions. The program is anticipating the arrival of specific charts for conducting assessments of the CSHCN population.

  The work group for CSHCN determined that this should be viewed as a main priority health problem for this population.

Morbidity Trends

The diabetes control program has reported alarmingly high prevalence rates for diabetes in the Territory. The program initiated a diabetes registry in 1995 which had 4,380 registered diabetic cases representing a prevalence rate of **82.6 per 1,000** people. While the Year 2000 Objectives target a rate of 25 per 1,000 people, the prevalence rate of 82.6 per 1,000 represents a severe problem in this area. Further, reportedly one half of all dialysis patients treated at the hospital are diabetic. While it is commonly known that roughly half of all diabetics in the U.S. are unidentified, the reality for the pacific island Territory of American Samoa could be staggering.

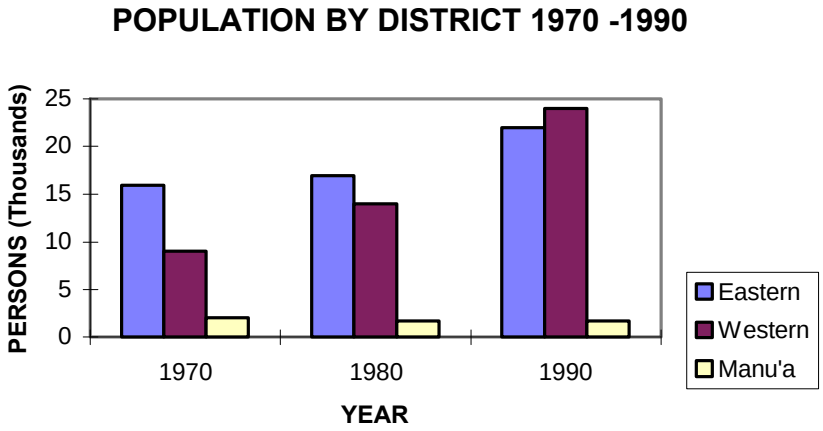
Previous studies in the Territory have documented an excessively high prevalence of obesity in the Samoan population (McGarvey, 1993) For some age groups, percent of overweight is reported to be 80-90%. Severe obesity is said to be the result of rapid modernization, most notably, changes in diet from the traditional “Samoan diet” to one of highly processed foods and canned meats very high in fat and sodium. This problem is further exacerbated by a lack of readily available fresh foods. Fresh fruits and vegetables are imported from the U.S and New Zealand via airfreight or ship. This adds to the cost of the produce making them prohibitively expensive to many people. The Pacific jurisdictions in general, and American Samoa specifically experience high rates of other so called "lifestyle" illnesses such as heart disease, hypertension and diabetes.

Nutrition program says that 32% of children under 5 are iron deficient.

Mortality trends in American Samoa, most notably, the Infant Mortality rate, have been increasing in recent years. The infant mortality rate using aggregated data over a 3 year period of time shows that the infant mortality rate has been increasing in recent years. The 1999 data reported in this Needs Assessment shows a slight reversal in this trend (12.7) but analyses of this rate over time will determine if there is any significant decrease in this rate.

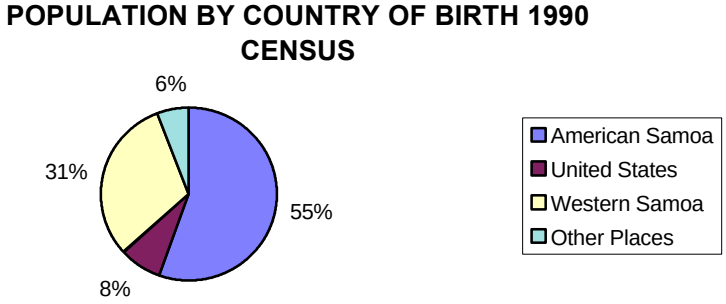
Health Disparities

Tualauta County is a heavily, densely populated are on the main island of Tutuila. Two of the main villages within this county are Tafuna and Nuu'uli and they are located in the Western District of the island. Based on the 1990 U.S. census, the population of Tafuna in 1996 is estimated to be 6,424 and the population of Nuu'uli is estimated at 4,761.



As evidenced by the above chart, the Western District of the island is the fastest growing. Historically, these villages have had a large percentage of freehold land. Most of the land available in the Territory is not available for purchase, rather can only be given or exchanged between persons of Samoan ancestry. Of the total land area of the Territory, only 14 percent of the land can be bought by persons of non-Samoan ancestry. A great proportion of this freehold land is located in the villages of Tafuna and Nuu'uli. As a result, these villages have been the fastest growing villages on the island in terms of population growth. Huge numbers of persons of Western Samoan and non-Samoan ancestry have purchased parcels of land and built homes in this area. The majority of these people tend to be of Western Samoan or Tongan descent. These settlements of Western Samoans and Tongans tend to be ***extremely*** overcrowded and standards of life tend to be ***below*** that of the overall quality of life enjoyed by the greater Samoan community. Homes are built very close together and many

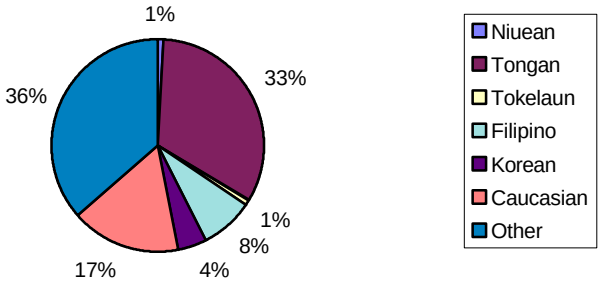
family members share the same small living quarters. Often times, buildings are not built according to safety codes and do not contain adequate plumbing and lavatory facilities. The combination of all of these life-circumstances result in a marginalized population at environmental risk of a myriad of negative health outcomes. The graph below illustrates the huge proportion of the population (31%) which has immigrated from neighboring Western Samoa, an independent developing island nation with a per capita income far below that of American Samoa.



Although no real data exists to substantiate this, it is commonly known that Tongans and Western Samoan represent marginalized populations who access the health care system at a disproportionate rate. Many tend not to practice preventive health care measures and tend to access the "crisis care" or emergency care system when health conditions become intolerable. Tongans and Western Samoans have a greater tendency to practice local medicine which certainly has it's place among respected health care practices. However, modern health care interventions and medical practices are essential during those times when traditional healing practices fail. These culturally isolated populations, however, have a tendency towards using traditional medicine as their sole means of health care and health maintenance.

The overall marginalization of this population is exacerbated by the economic reality for these ethnic groups. The cost of care to non-residents are rather high. Although medical clinic visits are $2 per visit regardless of residency status, the possibility of hospital admission would result in a $60. fee per night. This is extremely low when compared to U.S. standards, however, this population tends to suffer from unemployment and underemployment at a very high rate resulting in economic isolation from the existing health care system. Many of the Western Samoan and Tongan guest workers are employed by the tuna canaries at a rate of $2 - $3 per hour. Many others are not employed at all, relying on a subsistence level of living. The pie chart below effectively illustrates that the Tongan population represents fully 33% of the non-Samoan population. Many of these people are unemployed, relying on a subsistence lifestyle or have a family member working at the canaries at very low hourly wages.

ETHNICITY OF THE NON-SAMOAN POPULATION 1990 CENSUS



Geographic isolation is another factor resulting in the inaccessibility of the existing health care system to these populations. About two thirds of the island's land area is steeply sloping and virtually inaccessible. The more isolated areas of the island tend to be inhabited by these underserved "pockets" of the population. These parts of the island tend to be far from the main road and a great distance from public transportation. Many of the isolated rural areas have no roads at all, only bush paths which are extremely muddy during the rainy season.

Tualauta County has been targeted by Title V in the past 5-year grant cycle and these targeted efforts will continue into the next 5-Year cycle. The Territorial outcome measure is to decrease the disparity between the infant mortality rate in Tualauta county and the rest of American Samoa. Data shows that the infant mortality rate in Tualauta County reached 20 per 1,000 live births in 1998 (3 year average) and single year data 1999 shows an infant mortality rate of 17 per 1,000. A closer examination of the more specific rates (neonatal, post neonatal mortality rates) and more qualitative research into this situation is anticipated in the upcoming year in cooperation with the CDC funded MCH Epidemiology Program.

3.1.2.2 Direct Health Care Services
3.1.2.3 Enabling Services

Primary and preventive health care services are universally accessible in American Samoa. Specialty care services are accessible sporadically on island and, in extreme cases, through the off-island referral program. Financial access to health care becomes a problem in areas of high immigrant populations. (see discussion of Tualauta County above 3.1.2.1).

The cultural acceptability of health care is another area of concern. Many of the indicators of access to preventive and primary care show a low utilization of existing services. (e.g. Prenatal care) The issue of cultural acceptability will be addressed in further qualitative research studies.

The determined priority Territorial concerns in the area of Direct Services and Enabling services are as follows:

- To increase the percent of women with a live birth who have received adequate prenatal care as determined by the Kotelchuk Index.
- To increase the percent of children with special needs who have received an annual reevaluation by an interdisciplinary team.

There has been no change in the level of coverage from Medicaid in the past year.
"Managed care" is a concept that does not apply to the situation in American Samoa
Welfare reform does not apply to American Samoa.
SSI also does not apply to American Samoa.
CHIP is available to American Samoa in a lump sum and is distributed to the Hospital. The CHIP committee (which includes the MCH Coordinator) makes decisions regarding distribution of these funds on the local level. A dental initiative will be the result of American Samoa CHIP funds.

All health care services are available on island or through agreements with off-island facilities as needed. Physical Therapy / Occupational Therapy is one notable exception to this.

3.1.2.4 Population-Based Services

The determined priority Territorial concerns in the area of Population-based services are as follows:

- To increase the percent of children with completed immunization among the children with special needs who are known to the CSN Program.
- To increase the percent of children with special needs who have received all of the recommended services within 12 months of the date of recommendation.
- To increase the percent of 6 month old infants who attend the Well Baby Clinic at 6 months of age who are exclusively breastfeeding
- To decrease the percent of adolescents in Grades 9-12 who report smoking cigarettes within the past 30 days.

3.1.2.5 Infrastructure Building Services

The determined priority Territorial concerns in the area of Infrastructure-Building services are as follows:

- To decrease the percent of 2, 3, and 4 year old children who are seen in the MCH Well Child Clinic who have dental caries on examination.

3.2 Health Status Indicators

Many of the Core National Health Status Indicators have very little or no relevance to American Samoa. For example, Medicaid and CHIP related measures are impossible to examine in the particular health care setting in American Samoa.

Title V staff found Health Status data on access to prenatal care to be highly relevant to the situation in American Samoa. Examination of prenatal care in the contest of the Kotelchuk Index resulted in a further exploration of the use of this index. Use of this index was further chosen as a Territorial performance Measure.

All other areas of priority need and the development of performance measures took place as a result of discussions among the three individual work groups and the scoring method for determining priority needs.

3.2.1 Priority Needs

- To increase the percent of women with a live birth who have received adequate prenatal care as determined by the Kotelchuk Index.
- To increase the percent of children with completed immunization among the children with special needs who are known to the CSN Program.
- To increase the percent of children with special needs who have received all of the recommended services within 12 months of the date of recommendation.
- To decrease the percent of 2, 3, and 4 year old children who are seen in the MCH Well Child Clinic who have dental caries on examination.
- To increase the percent of 6 month old infants who attend the Well Baby Clinic at 6 months of age who are exclusively breastfeeding.
- To increase the percent of children with special needs who have received an annual reevaluation by an interdisciplinary team.
- To decrease the percent of adolescents in Grades 9-12 who report smoking cigarettes within the past 30 days.

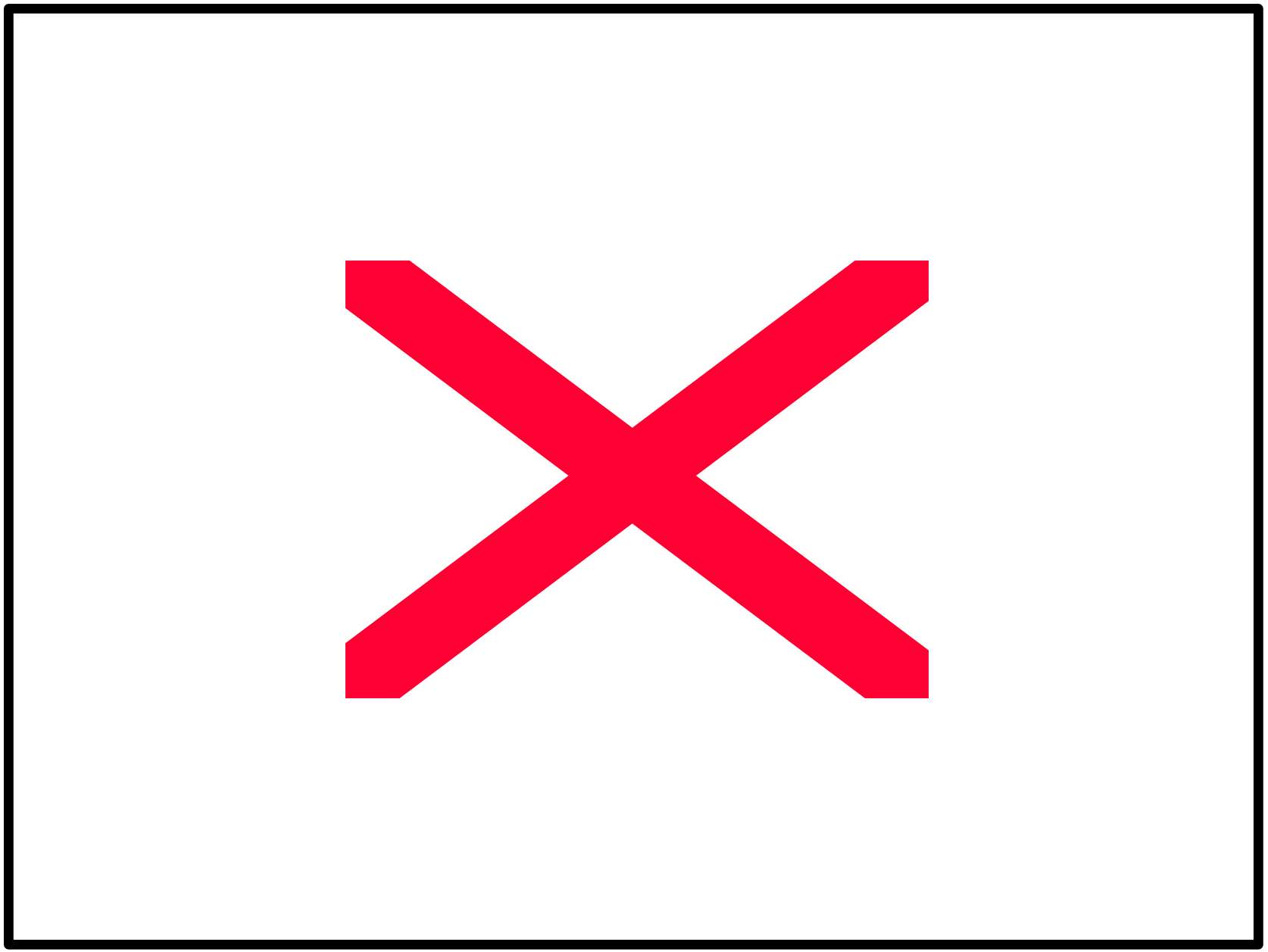
3.3 Annual Budget and Budget Justification

3.3.1 Completion of Budget Forms

3.3.2 Other Requirements

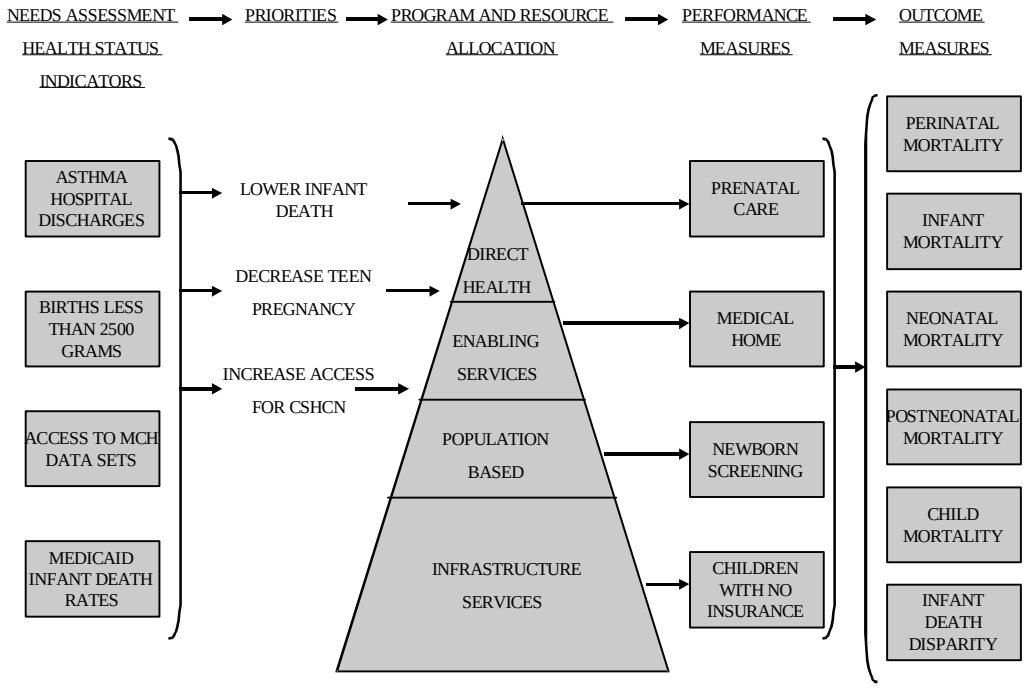
There have been no variations in the maintenance of effort from 1989. American Samoa has consistently maintained a ¾ in-kind match for federal funds.

3.4 Performance Measures



3.4.1 National "Core" Five Year Performance Measures

Figure 3
TITLE V BLOCK GRANT
PERFORMANCE MEASUREMENT SYSTEM



3.4.1.1 Five Year Performance Targets

FIGURE 4
PERFORMANCE MEASURES SUMMARY SHEET

Core Performance Measures	Pyramid Level of Service				Type of Service		
	DHC	ES	PBS	IB	C	P	RF
1) The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.	X				X		
2) The degree to which the State Children with Special Health Care Needs (CSHCN) Program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients.	X				X		
3) The percent of Children with Special Health Care Needs (CSHCN) in the State who have a "medical/health home."		X			X		
4) Percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinopathies (e.g., the sickle cell diseases) (combined).			X				X
5) Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B.			X				X
6) The birth rate (per 1,000) for teenagers aged 15 through 17 years.			X				X
7) Percent of third grade children who have received protective sealants on at least one permanent molar tooth.			X				X
8) The rate of deaths to children aged 1-14 caused by motor vehicle crashes per 100,000 children.			X				X
9) Percentage of mothers who breastfeed their infants at hospital discharge.			X				X
10) Percentage of newborns who have been screened for hearing impairment before hospital discharge.			X				X
11) Percent of Children with Special Health Care Needs (CSHCN) in the State CSHCN				X	X		

Program with a source of insurance for primary and specialty care.							
12) Percent of children without health insurance.				X	X		
13) Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.				X		X	
14) The degree to which the State assures family participation in program and policy activities in the State CSHCN Program.				X		X	
15) The rate (per 100,000) of suicide deaths among youths 15-19.				X			X
16) Percent of very low birth weight live births.				X			X
17) Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.				X			X
18) Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.				X			X

Negotiated Performance Measures	Pyramid Level of Service				Type of Service		
	DHC	ES	PBS	IB	C	P	RF
SP 1: Percent of Infants born to women receiving adequate Prenatal Care according to the Kotelchuk Index	X						X
SP 2: Percent of Children with Special Health Care Needs (CSHCN) who have age appropriate completed immunizations.			X		X		
SP 3: Percent of CSHCN who have received all services recommended by their individual service plan.			X		X		
SP 4: Percent of 2, 3 and 4 year old children in the Well Child Clinics who have dental caries.				X	X		
SP 5: Percentage of six month old infants exclusively breastfed in Well Baby Clinics.			X		X		
SP 6: Percentage of Children with Special Health Care Needs who have received an annual re-evaluation by the interdisciplinary team		X			X		
SP 7: Percent of 14-17 year old teenagers attending school who admitted to smoking in the			X				X

last 30 days.							

NOTE: DHC = Direct Health Care ES = Enabling Services PBS = Population Based Services
IB = Infrastructure Building C = Capacity P = Process RF = Risk Factor

3.4.2 State "Negotiated" Five Year Performance Measures

3.4.2.1 Development of State Performance Measures

3.4.2.2 Discussion of State Performance Measures

Each year, the development of this Title V application and annual report occurs over a period of several months and is representative of a collaborative effort of all MCH staff members and leadership. The MCH Consultant, Dr. Henry Ichiho facilitated discussions and held workshops, on island, which focused on the 5 Year Needs Assessment. Further, through the **Pacific Island's Distance Learning program** developed by Dr. Andrea Guillory and Dr. Henry Ichiho of the University of Hawaii MCH Training Program, American Samoa Title V staff were assisted in progressing through each stage in the cycle in the development of the five-year Needs Assessment. This process culminated in the development of 7 new State-negotiated performance measures. This year's application presented an opportunity to re-visit data generated last year and re-assess the relevance of the 10 State measures developed during the last cycle. Some data problems were discovered and are discussed in this years' application. Every effort is being made to improve the integrity of the data presented. The new focus of SSDI will certainly afford an opportunity for improving the data system and the quality of the data in general.

The following represents a discussion of the new State Performance measures. The first two years of the new focus on performance measurement proved to be a learning experience where the development of the Needs Assessment resulted in the elimination of the old measures and the adoption of 7 new measures.

Each Performance Measure is directly correlated to each of the 7 Priority Needs.

SP1: Percent of infants born to women receiving adequate Prenatal Care according to the Kotelchuk Index.

This performance measure was chosen because of the very low percentage of women who access prenatal care in the first trimester in American Samoa. Title V, by choosing this as a performance measure and priority needs, would like to re-affirm it's commitment to addressing this problem by channeling resources into this area.

Although a National Health Status Indicator already requires an examination of prenatal care with regard to the Kotelchuck Index, it is believed that an examination of adequacy in relation to time of initiation of prenatal care overlooks a key element of the problem in American Samoa. Most women are initiating prenatal care in the second and *third* trimesters.

This performance measure is a Direct Health Care performance measure.

This performance measure has a direct relationship to several of the Outcome Measures:

- Infant mortality rate
- Neonatal mortality rate
- Post neonatal mortality rate
- Perinatal mortality rate
- Child death rate

SP2: Percent of Children with Special Health Care Needs (CSHCN) who have age appropriate completed immunizations.

This performance measure was chosen because of the low immunization rates found within the population of CSHCN in American Samoa. With a relatively small, "captive" population in an island setting, the expected percentage of CSHCN with completed immunizations should be far higher. This measure is very attainable and has a high level of effectiveness of intervention.

This performance measure is a population based service.

This performance measure has a direct relationship to the following Outcome Measure:

- Child death rate

SP3: Percentage of Children with Special Health Care Needs who have received all the services recommended by their individual service plan.

This Performance measure was chosen in an effort to improve the overall quality of life for the CSHCN population. The activities will be centered on the re-establishment of the Interagency Team. With a relatively small, "captive" population in an island setting, the expected percentage of CSHCN receiving all services within the scope of their Individual Service Plan should be far higher. This measure is very attainable and has a high level of effectiveness of intervention.

This Performance Measure is a Population Based performance measure.

This performance measure has a direct relationship to the following Outcome Measure:

- Child death rate

SP4: Percent of 2, 3, 4 year old children in the Well Child Clinics who have dental caries.

This Performance measure was chosen because of the high rate of dental caries found in the pre-school population. Significant dental caries can result in poor feeding practices, which are directly related to compromised nutritional status. The School Health Team has determined that 85% of children attending Early Childhood Education programs were found to have dental caries. Therefore, American Samoa Title V has chosen to focus efforts on reducing the rate of dental caries in the population of 2, 3 and 4 year olds.

This is an infrastructure building performance measure.

This performance measure has a direct relationship to the following Outcome Measure:

- Child death rate

SP5: Percentage of 6 month old infants exclusively breastfed in Well Baby Clinics.

This performance measure was chosen by Title V staff in response to the very low rate of breastfed babies at 6 months of age. Recent examination of this data revealed that only 10% of 6 month old babies enrolled in Well Baby Clinics are exclusively breastfed. Title V staff have taken the position that this level of performance can and should be elevated. The expected outcome of increased breastfeeding will be overall improvements in infant health. Empirical data shows that breastfeeding of infants results in improved infant morbidity and mortality outcomes. Bottle-feeding is directly linked to increased dental caries and compromised nutritional status of infants.

Title V has attempted to measure the rates of breastfeeding at 6 months in the WIC population. WIC does provide a captive population, which is easily measurable. Limited success of Title V in obtaining data from WIC, however, has resulted in MCH staff exploring other avenues for obtaining valuable data concerning breastfeeding rates at 6 months. Title V staff believe that this measure of breastfeeding at 6 months is a more meaningful assessment of breastfeeding rates in the Territory than the National Performance Measure which examines breastfeeding at hospital discharge.

This performance measure is a population based service.

This performance measure has a direct relationship to several of the Outcome Measures:

- Infant mortality rate
- Neonatal mortality rate
- Post neonatal mortality rate
- Child death rate

SP6: Percentage of annual re-evaluation of Children with Special Health Care Needs by Interdisciplinary Team.

This Performance measure was chosen in an effort to improve the overall quality of life for the CSHCN population. The activities will be centered on the re-establishment of the Interagency Team to result in coordinated efforts towards the annual re-evaluation of CSHCN children. With a relatively small, "captive" population in an island setting, the expected percentage of CSHCN receiving all services within the scope of their Individual Service Plan should be far higher. This measure is very attainable and has a high level of effectiveness of intervention.

This performance measure is an enabling service.

This performance measure has a direct relationship to the following Outcome Measure:

- Child death rate

SP7: Percent of 14-17 teenagers attending school who admitted to smoking in the last 30 days.

Results of the Youth Risk Behavior Survey (YRBS) in 1999 showed that 40% of teenagers ages 14-17 have admitted to having a puff of a cigarette in last 30 days. The Title V staff and leadership have decided that clear and determined efforts must be made towards addressing the specific health concerns of the island's adolescent population.

This performance measure is a population based measure.

This performance measure has a direct relationship to the following Outcome Measure:

- Child death rate

3.4.2.3 Five Year Performance Targets

3.4.2.4 Review of State Performance Measures

3.4.3 Outcome Measures

IV. REQUIREMENTS FOR THE ANNUAL PLAN

4.1 Program Activities Related to Performance Measures

In establishing the relationship between the priority areas, the performance measures and the available capacity of the MCH Program, a matrix of the performance measures was developed so that clusters of activities within various programs may be developed.

	Pregnant/mother/infant	Children	Children special needs
Direct Health	S1 Adequacy of PNC		N2 Specialty service
Enabling			N3 Medical home S6 CSN annual re-evaluation
Population-based	N6 Teen births N9 Breastfeed, hospital	N5 Immunization, 2 yr N7 Dental sealants N8 MV deaths S2 CSN Immunizations S3 CSN receive recommended services S5 Breastfeeding of 6 month olds S7 Teen smoking	S2 CSHCN immunizations S3 CSHCN receive all services needed S6 CSHCN annual re-evaluation
Infrastructure	N18 First trimester PNC	N12 No insurance N13 Medicaid N15 VLBW N16 Teen suicide S4 Dental caries in ECE population	N11 Insurance N14 Family participate

The priority areas for American Samoa are reflected in the following State Negotiated Performance Measures:

- To increase the percent of women with a live birth who have received adequate prenatal care as determined by the Kotelchuk Index.
- To increase the percent of children with completed immunization among the children with special needs who are known to the CSN Program.
- To increase the percent of children with special needs who have received all of the recommended services within 12 months of the date of recommendation.
- To decrease the percent of 2, 3, and 4 year old children who are seen in the MCH Well Child Clinic who have dental caries on examination.
- To increase the percent of 6 month old infants who attend the Well Baby Clinic at 6 months of age who are exclusively breastfeeding.
- To increase the percent of children with special needs who have received an annual reevaluation by an interdisciplinary team.
- To decrease the percent of adolescents in Grades 9-12 who report smoking cigarettes within the past 30 days.

The following discussion is organized around each of the four levels of services as described in the pyramid model. Within each of the four levels, the plans and activities for each of the three specific targeted populations with the National and State performance measures associated with that level of service and the target population will be discussed.

DIRECT HEALTH CARE SERVICES

Pregnant women, mothers, infants - Based on progress of data and the experience of staff members, the top 3 priority areas in order of importance are as follows: (1) Increase the number of women seeking first trimester prenatal care and improving the quality of prenatal services; (2) Improve the immunization rate of infants and children; (3) Improve nutrition of pregnant women, infants, and school age children. The current discussion will focus on the third area of improving the nutritional status of women and infants.

MCH nutrition and breast-feeding education and counseling services will continue to be available to pregnant women. The MCH health educator will visit each dispensary weekly to provide counseling and discuss prenatal outcomes. These services will be provided as one on one counseling at prenatal visits at dispensaries, and at WIC. It is anticipated that these education sessions will be given to an optimum number of prenatal women a year.

For post-partum women, the initial MCH nutrition and breast feeding education and counseling services will be given 24 hours after delivery. Efforts will be made to initiate breastfeeding immediately following delivery, and during the post-delivery inpatient period. Training will be provided to facilitate cooperation with Nursery and Maternity Ward staff to promote breastfeeding. The policies developed by the breastfeeding committee will be revised and reactivated. Additional nutrition and breastfeeding education sessions will be provided to an optimum number of mothers at well baby clinics, the hospital, and at WIC.

The MCH Health Educator and health care providers who conduct follow-up post-partum care will evaluate and discuss the following topics: baby care, family support systems, and social/economic status. For working mothers, support will be provided towards transitional plans before returning to work. High-risk post-partum women with established chronic medical conditions will be referred for continuation of care.

Infants will continue to be assessed and screened during the well baby clinics at designated times. At these times the primary care provider will provide nutritional, breastfeeding, and developmental information. Other information provided includes skin and scalp care, teething, treatment of fever, and other common infant health problems such as vomiting, diarrhea, cough, and runny nose, first aid, and injury prevention. The level of the infant's hemoglobin is checked at six months of age. The infant is assessed

earlier if there are clinical signs of anemia or if the mother has changed from breastfeeding to a non-iron fortified formula. The infant will be weighed and measured for height to monitor growth and development.

Well Baby/Well Child restructuring resulted in the development of educational modules which address topics related to common health, nutrition and safety issues to be provided on a one-on-one basis to caretakers at each clinic visit with respect to the age of the child at the time of the visit. (Age-appropriate preventive topics) These individual sessions have been scheduled according to the immunization schedule except the 9 months and 3 years old visits. In addition, each patient found to have a problem, will be referred to an MCH physician who will address all problems screened for during the well baby/well child clinics. At this time, problems will be assessed and managed appropriately.

In order to assure if these activities were performed, the providers at each clinic will be provided a tickler system sheet where each of the sessions is ticked if it was performed. The well baby care health education modules have been completely developed and are currently being implemented at the dispensary level.

All mothers will be interviewed at the first month Well Baby visit about their feeding choices, and those mothers not currently breast-feeding their infants will be encouraged to do so. The MCH health educator conducts health education activities centered around general child health and well-being, skin care, fever management, personal hygiene, respiratory conditions, food preparation etc. Nutrition staff will implement and monitor the breast-feeding education and promotion activities on a one on one basis (5 a day). These activities will be evaluated by determining the number of presentations made, the number of women contacted, and the number of women interviewed at one month appointments along with records of mothers' feeding decisions.

Developmental information according to the Denver Scale will be utilized. Other information provided includes skin and scalp care, teething, treatment of fever, and other common infant health problems such as vomiting, diarrhea, cough and runny nose, first aide, and injury prevention.

The level of the infant's hemoglobin is checked at six months of age. The infant is assessed earlier if there are clinical signs of anemia or if the mother has changed from breastfeeding to a non-iron fortified formula. The infant will get weighed and measured for height to monitor for normal growth and development.

A plan to initiate outreach education and health promotion at the village level, in an effort to pull away from dispensaries will be put into action in five of the most densely populated villages on island.

Children - The Territory of American Samoa will provide the following services to infants and children ages 0-21: well baby and well child health care clinics where physical and medical assessments will be done periodically to screen and monitor

growth and development. If health problems (dysnutrition, respiratory infections, gastroenteritis, and skin problems) are noted, then specific health education will be provided. Immunizations will routinely be administered to children 1month to 6 years of age according to the recommended schedule. In addition, infants born to Hepatitis B positive mothers will routinely be followed by the Hepatitis B staff and managed appropriately.

Children with special needs - The primary activity for the CSN program will continue to provide assessments for those children identified with possible chronic or disabling conditions to determine their needs, to empower and facilitate them to live within their communities in an acceptable way and to achieve their full potential. These assessments and reviews will be carried out in the home setting rather than at the Dispensaries or specially held clinics. Home visits will continue to be carried out by the, medical officer, general practitioner, case manager, and nutrition assistant and nursing assistants. Occasional assessments and reviews will continue to be held during well baby clinics. These assessments and reviews involve a holistic approach with counseling and advice on a range of issues such as those relating specifically to the disability (stimulation, positioning and handling, safety) and those relating to general health (immunization, hygiene, skin and dental care). Other direct services will continue to include: (a) Cooperation with Special Education services of the Department of Education, assistance given in developing a family management plan and/or Individual Education Plans (IEP) either in school or at home visit. (b) Advice about special management and handling techniques. Equipment will be provided to teachers in order to work with special education classes at Matafao School and for teaching children with special needs in normal school classes. (c) Some gap filling medical treatment especially for children with epilepsy and muscle spasm will be provided for individual patients during review assessments. (d) Regular visits will continue to the respite care center to provide direct medical services for children with severe and multiple disabilities.

SP1: Percent of infants born to women receiving adequate Prenatal Care according to the Kotelchuk Index.

- Initiate an incentive program for women who access prenatal care in the first trimester. Incentives include t-shirts, calendars etc. If visits are continuous up to 38 weeks, the patient will be given a baby-care kit.
- Media campaign through newspaper, radio spots TV advertisements, and signposts
- Targeted community awareness campaigns at the most heavily populated work areas including the canneries, office buildings etc.
- Monthly health education outreach sessions will be conducted at the major workplaces. The Health and Safety Manager will be contacted by the MCH Health Educator in order to conduct health education sessions during the designated work break times. Target groups will be both men and women in the childbearing age groups.

N2: The degree to which the State Children with Special Health Care Needs (CSHCN) Program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients.

American Samoa is unique in that the Government Code states that Health Services, primary, specialty and subspecialty services including care coordination are available to all residents including CSHCN, free of charge. The American Samoa CSN Program therefore, does not have to provide or pay for services for any specific individual.

ENABLING SERVICES

Pregnant women, mothers, infants - Translation of educational materials and modules will facilitate health education (whether in group or individual setting) in the prenatal/postnatal, well baby/child, outpatient, village/community-based clinics, and inpatient wards.

By decentralizing Prenatal/Postpartum and Well Baby/Child Clinics (from the Hospital to the Dispensaries) accessibility to health care providers is increased, thereby increasing number of contacts and educational opportunities for the clients. Outreach to the villages, community groups, and respite care facilities at periodic intervals also enhance the health education efforts.

Home visits to high-risk patients such as children with special health care needs, and low socio-economic status, and failure to thrive will continue in coordination with other programs such as WIC, Nutrition, CSHCN, and the Discharge Planning area of the Hospital.

Family Planning (program primarily responsible for health education on teen pregnancy issues) has submitted a plan to open an outreach clinic in a new location away from the hospital to target younger population (teen - early 20's). Health education, counseling, and contraceptive materials will be available to clients there. Also, the Women's Health Clinic will be moving to a new location on the west side of the island to make women's health care more accessible to clients. Both the Teen Family Planning Clinic and the Women’s Health Clinic on the west side of the island are long term goals of the respective programs.

Children with special needs - The CSN team will continue to conduct assessments and review in the home setting rather than a clinic setting to ensure enabling of more children to access the service. The team will arrange referrals and facilitate access to agencies or services to help meet particular CSN requirements. These will include: (a) Family support services especially WIC and ASNAP programs, Social Services worker, Child Protection Services. (b) Referrals to medical specialty services (eye, ENT, orthopedic and pediatric). (c) Referral to Department of Education Special Education Services. (d) Arranging respite care services.

The CSN Program will begin to work closely with the Dispensaries in the screening process of new school entrants for chronic and disabling conditions. Due to shortness of staff and, in order to increase accessibility, this will be done in the dispensary. Nurses in the dispensaries will do physical assessments of all new entrants to school. When a potential CSN is identified, he/she will be referred to the CSN team for further evaluation.

N3: The percent of Children with Special Health Care Needs (CSHCN) in the state who have a "medical/health home".

Currently in American Samoa, the CSHCN population does not have a medical/health home', by definition. A unique situation takes place with the AS-CSHCN population in that most families of CSN children develop a "family home" relationship with the CSN staff. This comes about because of the frequent home and school visits and if they have concerns will contact the staff who will arrange and facilitate provision of the service needed. This is the uniqueness of the CSN Program in American Samoa.
This allows 100% of CSN children in American Samoa to meet the definition of "medical home".

SP6: Percentage of annual re-evaluation of Children with Special Health Care Needs by the CSN Team.

The CSN Team will continue its monitoring functions by conducting active case-management of all CSHCN children. Currently, only 8% of CSHCN children are re-evaluated on an annual basis.

Plans for 2001 to increase this number include:

- individual home visiting in which the entire team (including the physician, nutrition staff and CSN Team) re-evaluate the child in the home setting.
- appointments will be scheduled in cooperation with DOE in order to conduct comprehensive assessments in the school setting.
- appointments will also be made in cooperation with the Respite Care Center in order to conduct comprehensive evaluations which include the physician, nutrition staff and the CSN Team.

As a further effort towards meeting this performance objective, the CSN team is exploring options for hiring a Physical Therapist/ Occupational Therapist. The Interagency Team will discuss possibilities for cost sharing for this position.

POPULATION-BASED SERVICES

Pregnant women, mothers, infants – In order to increase to the percent of mothers in the WIC program who exclusively breastfeed their infants at 6 months of age, a number of activities are planned for the upcoming year. Health education on the importance of breastfeeding and proper nutrition will be provided at clinic prenatal visits, post partum clinics well baby/well child visits as well as at hospital discharge after

delivery. In an effort to increase public awareness, TV and radio spots will be developed on the health benefits of breastfeeding.

The teen birth rate will be maintained by health education relevant to teen population in the Family Planning Clinic, in outreach to schools, and the dispensing of contraceptives. Efforts will represent a combined effort with the Family Planning Program in order to improve efficiency of funds and work towards the accomplishment of common goals.

SP2: Percent of Children with Special Health Care Needs (CSHCN) who have age appropriate completed immunizations.

- the CSN team will coordinate efforts with the dispensary nurses, district coordinator QA Coordinator to assure that all csn children attending school are immunized during the annual exams. The annual exams are conducted by the CSN team in an ongoing effort to monitor and improve the delivery of services to this population.
- Children who do not attend school or who are otherwise missed in the school setting will be given appointments to access the district dispensary in order to receive immunizations.
- Children who are not immunized in the school setting nor at the dispensaries will be visited by a CSN team member along with a dispensary nurse who will administer the vaccine,

SP3: Percentage of Children with Special Health Care Needs who have received all the services recommended by their individual service plan.

- Reactivate the MOU which serves as an agreement whereby agencies agree to share information and coordinate services to the CSHCN population. This interagency agreement was activated in the past but has lapsed. In FY 2001, this MOU will be reactivated and will include the following agencies

    - Department of Health
        - Maternal & Child Health
        - Nutrition Program
        - CSN Program.
    - Department of Education:
        - Division of ECE/HeadStart
        - Division of Special Education
        - Elementary and Secondary Education Divisions
    - Department of Human & Social Services:
        - Division of Social Services
        - Division of WIC
        - Division of Vocational Rehabilitation
        - Developmental Disabilities Planning Council (DDPC)
    - Office of Protection & Advocacy for the Disabled (OPAD)

- LBJ Hospital Authority
  - In-patient as well as out-patient clinics
  - Part C

Upon successful re-activation of the MOU, the Interagency team will meet on a monthly basis in order to review records of CSN children to determine whether or not each child is receiving the services recommended in their individual service plan.

The CSN Team will continue its monitoring functions by conducting active case-management of all CSHCN children.

SP5: Percentage of 6 month old infants exclusively breastfed in Well Baby Clinics.

- The MCH Health educator will work closely with other health professionals within the Health Department in order to conduct qualitative research in the form of 4 focus groups at the village setting. Each focus group will include a discussion of at least 10 women of varying ages in order to discuss motivating factors which influence choices to initiate breastfeeding and breastfeed exclusively for the first 6 months of life.
- Health education sessions will be conducted in 4 prenatal clinics and the 2 caneries concerning the importance of breastfeeding,k
- Policy development…baby-friendly…..
- Revive the breastfeeding committee.

SP7: Percent of 14-17 year olds attending school who admitted to smoking in the last 30 days.

MCH staff will collaborate activities with the Tobacco Control Program during the Great American Smoke-out in November and Word No-Tobacco Day in May. Activities for this will include the following:

- MCH Health education staff will coordinate efforts with the Tobacco Control Program by assisting teenagers in the writing, performing and filming of a skit to be aired throughout the months of November and May. The focus of the skit will be to encourage teenagers to resist peer pressure and highlight examples of ways to resist tobacco products with confidence.
- The MCH Outreach Team in collaboration with the Tobacco Control Program will enter the 8 public and private high schools in order to assemble an informational booth which will be visible and accessible to all students and make available health education materials aimed at resisting smoking.
- Access 7 local high schools and initiate a poster contest among the grades 9-12. Top 3 winners will be awarded $1,000. in order to implement their school-based smoke-free campus activities.

N6: The birth rate (per 1,000) for teenagers aged 15 through 17 years

Efforts towards the accomplishment of this objective will be coordinated with the Family Planning Program. The family planning outreach nurse and MCH Health Educator will educate 60% of eleventh and twelfth graders about pregnancy risks, and family planning options during fiscal year 1999. The family planning nurse will provide educational presentations to high school students which will include a discussion of activities that can lead to pregnancy, family planning options available to both men and women, and reproductive health in general. Teenagers will be educated on abstinence, safer sexual practices, and informed about the consequences of STD's. The family planning nurse will maintain an outreach logbook where she will record all educational activities. The family planning nurse will submit an annual report describing the number of students contacted, the ages of the students and locations of the training.

The family planning nurse will conduct a clinic at a community location once per month during fiscal year 1999. This clinic will target teens with concerns over reproductive and family planning issues, sexually transmitted diseases, family or emotional problems, etc. The clinic will be an ideal first point of contact. It will be readily accessible and confidential. The family planning nurse will coordinate with other MCH nurses and educators to provide a broad range of applicable health services. The family planning nurse will record the number of students seen each month, their ages and reason for the visit. The family planning nurse will submit an annual report identifying the number of patients seen by age, and a summary of the services provided.

N9: Percentage of mothers who breastfeed their infants at hospital discharge.

During FY 1999, the Department of Health nutrition program staff will provide a variety of individual and group level education presentations on the importance of breast-feeding, and will cooperate with the WIC Program in developing the breastfeeding education modules. Women will be educated to the benefits and proper techniques of breast-feeding in prenatal and OB/GYN clinics, on the maternity ward following delivery. Information on anticipated problems encountered during breast feeding such as cracked nipples, engorgement, and infection will be emphasized. Proper breast-feeding techniques will be emphasized as well as what mothers can expect while breast-feeding. Mothers will be praised for choosing to breast-feed their infants.

A network of breastfeeding support groups similar to La Leche League will be initiated in order that mothers have peer support in the village and home setting. Women who give birth will be given the contact information for the group leader in her village. Every effort will be made to group together women with babies as close as possible to the same age. Group leaders will provide information to other mothers on common problems encountered in breastfeeding and overall support for making the choice to breastfeed her infant.

N5: Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B.

The present coverage is 75% and as shown American Samoa has not reached the national goal of 90%. Title V staff in collaboration with the Immunization Program will concentrate efforts on increasing this percentage in 1999. Steady improvement has been achieved in this performance measure during the past two years. The Department of Health Immunization Program plans to continue daily walk-in immunization clinics in the 6 Dispensaries. In the Well Baby/ Well Child Clinics an immunization follow-up policy will be instituted and this includes a reminder phone call for those who miss appointments and a home visit if the client has not come in for immunization after 2 reminder phone calls. The MCH Quality Assurance Specialist will monitor adherence to this policy.

A child who is acutely sick on the day he/she is scheduled to be immunized, is referred to the pediatric clinic for follow-up. Other children who are determined to have potential growth and development problems (poor nutrition, developmental delays, and failure to attain appropriate growth weight/height) are seen by an MCH physician at the dispensary.

The CDC Immunization Program will be a partner in this Performance Measure by providing a package of incentives and educational pamphlets will be provided at the 4 months visit. A significant drop in compliance with the well baby/well child clinic visits has been observed at the 4-month visit. Public awareness efforts will increase using TV programs, radio spots, newspaper articles and announcements (See State Performance Measure #8). Further, each June is designated as Immunization month. During this month, there is a mass media campaign to increase immunization awareness, incentives for children who are immunized during this month. The immunization health educator translates pamphlets, posters and brochures into Samoan for distribution at health centers.

N7: Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

Currently, sealants are provided for first, fourth, and eighth grade students by the Dental Outreach program. The infrastructural change required for appropriate measurement of this performance measure did not take place last year. The necessary change is target for 1999 as the MCH Program and Dental Health Services improve their collaborative efforts in this area.

MCH Coordinator, Chief of Dentistry, and MCH Consultant have agreed provide sealants for third graders rather than fourth graders beginning in year 2000. This change is currently reflected where 3rd graders are receiving sealants. The MCH program will provide sealants, fluoride and toothbrushes for 3rd grade students in order

to meet the national performance measure. Further, the MCH program will provide a dentist and a dental health educator Dental Outreach Program.

N8: The rate of death to children aged 1-14 caused by motor vehicle crashes per 100,000 children.

MCH will contribute to the accomplishment of the target by presenting health education modules which include motor vehicle safety during the well baby/child clinics. The dispensary nurses during well baby/well child clinics will continue to deliver these Health education modules in the upcoming program year. Further health education activities concerning motor vehicle safety will be conducted during health promotion weeks.

INFRASTRUCTURE BUILDING SERVICES

Pregnant women, mothers, infants

Infrastructure building services to women, mothers and infants will focus on systems-building efforts and a shift in the delivery of services to the population of women. Services will be decentralized and made available in the outlying clinics and incentives will be provided to those women who access prenatal care early.
Further activities include the following:

- breastfeeding committee will be revived
- work with hospital administration regarding overall baby-friendly hospital initiatives
- continue health education modules for prenatal care
- Use of prenatal modules, which focus on: breastfeeding, nutrition and overall self-care in regards to the pregnancy. This is intended to standardize and streamline the health education efforts with regards to the prenatal period
- mass media campaign (TV, Newspaper, radio) advertising, incentives
- Target canneries, government offices, public waiting areas etc…with posters and pamphlets…
- Workshop to be organized and facilitated by MCH on prenatal care and importance of accessing early and continuous care. Outreach education to include community leaders, church leaders, Pulenu'u, (village mayors) women's groups
- MCH Health Educator, Obstetrician and the Nurse Practitioner will conduct outreach to community groups, church groups etc.
- Increased inservice for staff

N18: Increase prenatal visits in first trimester

Efforts to increase prenatal attendance in the first trimester will begin as early as when couples are applying for marriage licenses, where they are met by the MCH Socail Worker and provided education on the positive outcomes of early attendance to Prenatal Clinic during first trimester.

To address the various barriers (transportation problems) to first trimester prenatal visit, MCH will continue to provide Prenatal Clinic in the Central District 1 Dispensary and has initiated a Prenatal Clinic in the Amouli (in the far eastern district of Tutuila) Dispensary. This dispensary became fully operational in this year.

Incentives for early and continuous prenatal care will be distributed. Incentives include T-shirts, towels, calendars, cups etc. At 38 weeks, the patient will get a kit with baby care items.

Bilingual and MCH health educators will continue to air 60-second television spots on the importance of early initiation of prenatal care. These television spots will be broadcast weekly to be broadcast weekly. A weekly newspaper column will be written for the local newspaper and will include information on early prenatal care, and how to have a healthy pregnancy.

Three times annually there will be a television program on the value of early prenatal care. It will be aired during a weekly Public Health Program. An annual health fair will be held. It will be a cooperative effort in which all public health programs will be represented. However, prenatal care will be one of the priority areas targeted.

During the summer months a mobile van will transport a team of professionals, including a nurse, nutritionist, health educator and others as needed, into the community for village clinics. Health education on the importance of early prenatal care will be one of the target areas for this team.

N15: Percent of very low birth weight live births.

The following activities will be undertaken to maintain at a very low level the percent of very low birth weight live births:

- Decentralize prenatal clinics further to include Amouli Dispensary to increase early prenatal attendance rate
- Monitor urine protein and sugar levels at every prenatal visit
- Early and periodic hemoglobin screening and treatment if anemic
- Increase accuracy of pregnancy dating (gestational age) through ultrasound-trained Obstetricians. This activity represents a partnering with the Breast and Cervical Cancer Program, which pays for some training for Obstetricians to obtain ultrasound training in Australia.

Children – MCH and the Dental Outreach Program will have a memorandum of understanding to share resources and to develop and implement a comprehensive preventable dental health program (education modules, incentives such as toothbrushes) and to implement fluoride and sealants to children. In addition, efforts will be undertaken to recruit a dental hygienist to provide school-based dental health education. Medical Services are provided free at all 6 health centers for all children and further comprehensive medical care is provided by the LBJ Tropical Medical Center for

a minimal administrative fee. American Samoa is unique in that Medicaid funds are not used to provide services to eligible children but are paid directly to the Department of Health. The amount of money received is based on the number of people assumed to be eligible using U.S poverty levels (approximately 56% of the total population.)
Suicide rates in American Samoa are comparatively low. It may be assumed that this is partly due to the strong family support system that still exists in American Samoa. MCH is still endeavoring to employ a social worker to provide further school based education on conflict resolution and self-esteem building.
Department of Health will be opening an additional prenatal clinic in Amouli thus increasing accessibility to prenatal care in the eastern portion of Tutuila, the main island.

SP4: Percent of 2, 3, 4 year old children in the Well Child Clinics who have dental caries.

In order to address this performance measure, MCH staff in cooperation with Dental services staff plan to conduct a community awareness campaign.

- in recognition of National Dental Health month, February, MCH Block staff intend to focus efforts throughout year 2001 on the 10 ECE schools in the Island's most heavily populated area (Tualauta County). Activities will include the following:
  - hands-on, interactive, child centered health education sessions in which children will have an opportunity to both observe and practice proper dental hygiene techniques.
  - Incentives (toothbrushes, dental floss, toothpaste) will be distributed to all children who attend these health education sessions.
  - A coloring book will be produced which encourages tooth-brushing, flossing and proper diet.
- monthly activities include tv spots, radio spots, newspaper articles on the importance of dental care. In addition to these activities, 2 television programs will be aired which focus on the importance of dental care in the population.
- A multivitamin with fluoride will be provided to all 2,3 and 4 year olds in well-child clinics.
- A protocol will be initiated in cooperation with Dental Health Services where 2-4 year old children who have observable dental caries at well-baby visits will be given immediate referral and follow-up on-site for dental care interventions.

N12: Percent of children without health insurance

The American Samoa Government provides free primary and specialty health care services to all it's residents for a small administrative fee. Private health insurance is not necessary in American Samoa and very few families carry policies with the exception of the military and few federal employees. Title V will continue to monitor this situation and assure that all children receive necessary medical care.

N13: Percent of potentially Medicaid eligible children who have received a service paid by the Medicaid Program

Medicaid funds are not distributed to the Territory on a fee for service basis. The Territory of American Samoa is unique in it's Title XIX status in that the Territory as a whole receives a lump sum of Medicaid funds to reimburse the Territory for services rendered. This sum has been negotiated on the Federal level according to population size combined with the fact the 58% of the population of American Samoa live at poverty level or below. Further, all preventive health services and medical care is delivered to the population free of charge for a small administrative fee. As a result, all Medicaid eligible persons receive a service paid for by Title XIX, including children.

Title V will continue to play a monitoring role with regard to potentially Medicaid eligible children. MCH staff will continue to assure that all children, including "Medicaid eligible" children receive necessary services. This will be done through well/baby well child visits and referrals of children for necessary medical services.

N16: The rate (per 100,000) of suicide deaths among youths 15-19.

The rate of suicide deaths among youths aged 15-19 is very low However, in order to maintain or decrease this level, MCH has hire a social worker who provides counseling to trouble youths referred to Public Health. In addition, the social worker provides education materials and lectures on problem solving and self esteem through schools and community clinics. These activities will continue in the following year.

Children with special needs – Plans for the year 2001, include a re-activation of the interagency leadership team. The MCH Coordinator as the lead member of this team will continue to work closely with all participating members of this coalition including, the CSN team. The Team includes the following members:

- Department of Education: Division of ECE/HeadStart
- Division of Special Education
- Department of Human & Social Services: Division of Social Services,
- Division of WIC
- Division of Vocational Rehabilitation
- Developmental Disabilities Planning Council (DDPC)
- Office of Protection & Advocacy for the Disabled (OPAD)
- Department of Health Services (now the LBJ Hospital Authority)
- Pediatric Ward including the Intensive Care Unit and the Newborn Nursery
- Part H
- Services provided through Maternal & Child Health e.g. Nutrition Program, CSN Program.

The CSN Team will be providing services to CSN in assisting them to attain age appropriate immunizations through scheduling for clients to come into through well-baby clinics or go out with the dispensary nurse to immunize at home.

Regular screening for possible chronic and disabling conditions will continue to be done through (a) Well Baby Clinic by the pediatricians and nurses; and (b) Attendance at the Pediatric Ward Rounds twice a week which include the Newborn Nursery and the Intensive Care Unit

In 2001, the Interagency Leadership Team will be re-established. As the lead member of the American Samoa Interagency Leadership Team (ILT), a coalition of private and government agencies/programs who provide a variety of services to those with disabilities, the CSN Team will engage in age-appropriate activities set by the ILT. These will include hosting and facilitating consumer workshops, participating in the Disabilities Awareness Month and its weeklong festivities, and usual television program slots.

CSN is planning a care provider and caretaker workshop. This workshop will include nutrition, positioning and sitting, safety measures and when to call for help. Participants will be teachers, physicians, (MCH and LBJ) nurses and nurses aids from the hospital and dispensaries, Respite Care staff, nutrition program WIC as well as care takers.

N11: Percent of Children with Special Health Care Needs (CSHCN) in the State CSHCN program with a source of insurance for primary and specialty care.

The American Samoa Government provides free primary and specialty health care services to all it's residents for a small administrative fee. Private health insurance is not necessary in American Samoa and very few families carry policies with the exception of the military and few federal employees. Title V will continue to monitor this situation and assure that all children including those with special health care needs receive necessary medical care.

N14: The degree to which the State assures family participation in program and policy activities in the State CSHCN program.

The CSN Program and staff will continue to encourage CSN families to participate in program and policy activities. Activities planned will include open forums and informative workshops on CSN conditions. Parents will be invited to ask questions pertaining to either their child's condition, the program, or to the staff. Through these open forums, the CSN staff will encourage the CSN parents/care providers to take a more pro-active approach to the decision-making processes for the appropriate services needed for their child. The CSN Team will continue to support family-based decisions and encourage families to be consultants for developing program policies and activities. The CSN Program will assist with the establishment of Health Advisory Committees to which parent representation will equal service providers.

As an additional activity to increase family participation in program and policy activities, the CSN Program will develop the position of a Parent Coordinator. This parent will facilitate a series of 6 meetings to be held in year 2000. The Parent Coordinator will call parents in order to provide reminders of meetings and encourage participation.

4.2 Other Program Activities

School Health Clinics- these clinics are conducted by the School Health Team in order to assess children in the Preschool, Kindergarten. Health assessments consist of heights, weights, blood pressures, dental assessments, nutritional status, skin problems, etc. In the event that a problem is identified by the school health team, a referral is made to the appropriate specialty service. An MCH Pediatrician accompanies the team and sees children who are identified as needing immediate attention.

The School Health Team conducts these assessments in order to effectively monitor the health status of preschool and kindergarten children on the island. The hospital offers a Pediatric Clinic for sick children only. The Territory has only one Pediatrician in private practice. The School Health Team, therefore, provides an essential service in monitoring the health status of school children. The School Health Team will travel to the outer island of Manu'a to conduct assessments and health education.

Oral Health Outreach- Title V activities include partnering with the LBJ School Dental team who is currently providing fluoride rinse and sealants to the children seen (in the 1^{st}, $3^{rd}/4^{th}$ and 8^{th} grades). The MCH Program partners with LBJ by cost sharing on sealants and other supplies as well as providing a full time dentist to manage all public health dentistry efforts. Future plans include working with the Department of Education (DOE) to start a fluoridation program in the schools. Title V is in the process of estimating potential costs for supplying fluoride to schoolchildren. This could involve Title V supplying fluoride supplements and providing training to teachers in order to conduct appropriate dental education (hygiene, nutrition, etc) in the classrooms. The Early Childhood Education program (ECE) also provides fluoride supplements to the children in their program.

Title V staff will participate in a number of conferences and workshops held off-island:

- One MCH staff member will attend the Annual AMCHP Conference
- One MCH staff member will travel to Honolulu to participate in the annual Coordinator's meeting
- One staff member will travel to participate in the annual Association of Pacific Nurses Leadership Conference to be held at a jurisdiction in the Pacific Region.
- One staff member will attend the Pacific Basin MCH Institute in the Pacific Region.
- Two MCH staff members will attend the MCH Grant Review in Honolulu.
- Four MCH staff members will travel to Manu'a during the year to provide outreach services.

4.3 Public Input

An advisory committee was convened in order to review the Application and Annual Plan. The Committee consists of a Health Planner, a Nutritionist and a consumer. They reviewed the plan in draft form and will continue to provide input into the plan after its submission. Their input was taken into consideration when developing the annual plan.

Further, the Block Grant Application in its entirety was made available for public review. Availability of the document at the Health Department was advertised in the daily newspaper.

4.4 Technical Assistance

The highest priority of Technical Assistance continues to be in the area of Data Systems Development. Within the Department of Health, there are a variety of categorical programs, which collect various data sets. Title V data requirements also necessitate the collection of data. A data plan is needed in order to assess data needs and the best possible means of data collection. The new focus of SSDI is expected to improve data collection activities significantly.

American Samoa is also requesting Technical Assistance with regard to Coalition Building. Title V leadership has observed that coalitions are initiated around certain areas but lack continuity. Technical assistance is requested in Coalition Building activities for the Advisory Group, CSHCN Interagency Team and Coalition Building for parent groups of CSHCN families.

V. SUPPORTING DOCUMENTS

5.1 Glossary

GLOSSARY

Administration of Title V Funds - The amount of funds the State uses for the management of the Title V allocation. It is limited by statute to 10 percent of the Federal Title V allotment.

Assessment - (see "Needs Assessment")

Capacity - Program capacity includes delivery systems, workforce, policies, and support systems (e.g., training, research, technical assistance, and information systems) and other infrastructure needed to maintain service delivery and policy making activities. Program capacity results measure the strength of the human and material resources necessary to meet public health obligations. As program capacity sets the stage for other activities, program capacity results are closely related to the results for process, health outcome, and risk factors. Program capacity results should answer the question, "What does the State need to achieve the results we want?"

Capacity Objectives - Objectives that describe an improvement in the ability of the program to deliver services or affect the delivery of services.

Care Coordination Services for CSHCN - Those services that promote the effective and efficient organization and utilization of resources to assure access to necessary comprehensive services for children with special health care needs and their families. *[Title V Sec. 501(b)(3)*]

Carryover (as used in Forms 2 and 3) - The unobligated balance from the previous year' s MCH Block Grant Federal Allocation.

Case Management Services - For pregnant women - those services that assure access to quality prenatal, delivery and postpartum care. For infants up to age one - those services that assure access to quality preventive and primary care services. *[Title V Sec. 501(b)(4)]*

Children -A child from 1st birthday through the 21st year, who is not otherwise included in any other class of individuals.

Children With Special Health Care Needs (CSHCN) - ***(For budgetary purposes)*** Infants or children from birth through the 21st year with special health care needs who the State has elected to provide with services funded through Title V. CSHCN are children who have health problems requiring more than routine and basic care including children with or at risk of disabilities, chronic illnesses and conditions and health-related education and behavioral problems. ***(For planning and systems development)*** Those children who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount beyond that required by children generally.

Children With Special Health Care Needs (CSHCN) - Constructs of a Service System

1. State Program Collaboration with Other State Agencies and Private Organizations

States establish and maintain ongoing interagency collaborative processes for the assessment of needs with respect to the development of community-based systems of services for CSHCN. State programs collaborate with other agencies and organizations in the formulation of coordinated policies, standards, data collection and analysis, financing of services, and program monitoring to assure comprehensive, coordinated services for CSHCN and their families.

2. State Support for Communities

State programs emphasize the development of community-based programs by establishing and maintaining a process for facilitating community systems building through mechanisms such as technical assistance and consultation, education and training, common data protocols, and financial resources for communities engaged in systems development, to assure that the unique needs of CSHCN are met.

3. Coordination of Health Components of Community-Based Systems

A mechanism exists in communities across the State for coordination of health services with one another. This includes coordination among providers of primary care, habilitative and rehabilitative services, other specialty medical treatment services, mental health services, and home health care.

4. Coordination of Health Services with Other Services at the Community Level

A mechanism exists in communities across the State for coordination and service integration among programs serving CSHCN, including early intervention and special education, social services, and family support services.

Classes of Individuals - Authorized persons to be served with Title V funds. See individual definitions under “Pregnant Women,” “Infants,” “Children with Special Health Care Needs,” “Children,” and “Others.”

Community - A group of individuals living as a smaller social unit within the confines of a larger one due to common geographic boundaries, cultural identity, a common work environment, common interests, etc.

Community-based Care - Services provided within the context of a defined community.

Community-based Service System - An organized network of services that are grounded in a plan developed by a community and that is based upon needs assessments.

Coordination (see Care Coordination Services)

Culturally Sensitive - The recognition and understanding that different cultures may have different concepts and practices with regard to health care; the respect of those differences and the development of approaches to health care with those differences in mind.

Culturally Competent - The ability to provide services to clients that honor different cultural beliefs, interpersonal styles, attitudes and behaviors and the use of multicultural staff in the policy development, administration and provision of those services.

Deliveries - Women who received a medical care procedure associated with the delivery or expulsion of a live birth or fetal death (gestation of 20 weeks or greater).

Direct Health Services - Those services generally delivered one-on-one between a health professional and a patient in an office, clinic or emergency room which may include primary care physicians, registered dietitians, public health or visiting nurses, nurses certified for obstetric and pediatric primary care, medical social workers, nutritionists, dentists, sub-specialty physicians who serve children with special health care needs, audiologists, occupational therapists, physical therapists, speech and language therapists, specialty registered dietitians. Basic services include what most consider ordinary medical care: inpatient and outpatient medical services, allied health services, drugs, laboratory testing, x-ray services, dental care, and pharmaceutical products and services. State Title V programs support - by directly operating programs or by funding local providers - services such as prenatal care, child health including immunizations and treatment or referrals, school health and family planning. For CSHCN, these services include specialty and subspecialty care for those with HIV/AIDS, hemophilia, birth defects, chronic illness, and other conditions requiring sophisticated technology, access to highly trained specialists, or an array of services not generally available in most communities.

Enabling Services - Services that allow or provide for access to and the derivation of benefits from, the array of basic health care services and include such things as transportation, translation services, outreach, respite care, health education, family support services, purchase of health insurance, case management, coordination with Medicaid, WIC and educations. These services are especially required for the low income, disadvantaged, geographically or culturally isolated, and those with special and complicated health needs. For many of these individuals, the enabling services are essential - for without them access is not possible. Enabling services most commonly provided by agencies for CSHCN include transportation, care coordination, translation services, home visiting, and family outreach. Family support activities include parent support groups, family training workshops, advocacy, nutrition and social work.

Family-centered Care - A system or philosophy of care that incorporates the family as an integral component of the health care system.

Federal (Allocation) (as it applies specifically to the Application Face Sheet [SF 424] and Forms 2 and 3) -The monies provided to the States under the Federal Title V Block Grant in any given year.

Government Performance and Results Act (GPRA) - Federal legislation enacted in 1993 that requires Federal agencies to develop strategic plans, prepare annual plans setting performance goals, and report annually on actual performance.

Health Care System - The entirety of the agencies, services, and providers involved or potentially involved in the health care of community members and the interactions among those agencies, services and providers.

Infants - Children under one year of age not included in any other class of individuals.

Infrastructure Building Services - The services that are the base of the MCH pyramid of health services and form its foundation are activities directed at improving and maintaining the health status of all women and children by providing support for development and maintenance of comprehensive health services systems including development and maintenance of health services standards/guidelines, training, data and planning systems. Examples include needs assessment, evaluation, planning, policy development, coordination, quality assurance, standards development, monitoring, training, applied research, information systems and systems of care. In the development of systems of care it should be assured that the systems are family centered, community based and culturally competent.

Local Funding (as used in Forms 2 and 3)-Those monies deriving from local jurisdictions within the State that are used for MCH program activities.

Low Income - An individual or family with an income determined to be below the income official poverty line defined by the Office of Management and Budget and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981. *[Title V, Sec. 501 (b)(2)]*

MCH Pyramid of Health Services - (see “Types of Services”)

Measures - (see “Performance Measures”)

Needs Assessment - A study undertaken to determine the service requirements within a jurisdiction. For maternal and child health purposes, the study is aimed at determining:

1) What is essential in terms of the provision of health services;

2) What is available, and
3) What is missing.

Objectives - The yardsticks by which an agency can measure its efforts to accomplish a goal. (See also "Performance Objectives")

Other Federal Funds (Forms 2 and 3) - Federal funds other than the Title V Block Grant that are under the control of the person responsible for administration of the Title V program. These may include, but are not limited to: WIC, EMSC, Healthy Start, SPRANS, AIDS monies, CISS funds, MCH targeted funds from CDC and MCH Education funds.

Others (as in Forms 4, 7, and 10) - Women of childbearing age, over age 21, and any others defined by the State and not otherwise included in any of the other listed classes of individuals.

Outcome Objectives - Objectives that describe the eventual result sought, the target date, the target population, and the desired level of achievement for the result. Outcome objectives are related to health outcome and are usually expressed in terms of morbidity and mortality.

Outcome Measure - The ultimate focus and desired result of any set of public health program activities and interventions is an improved health outcome. Morbidity and mortality statistics are indicators of achievement of health outcome. Health outcomes results are usually longer term and tied to the ultimate program goal. Outcome measures should answer the question, "Why does the State do our program?"

Performance Indicator - The statistical or quantitative value that expresses the result of a performance objective.

Performance Measure - A narrative statement that describes a specific maternal and child health need, or requirement, that, when successfully addressed, will lead to, or will assist in leading to, a specific health outcome within a community or jurisdiction and generally within a specified time frame. (Example: "The rate of women in [State] who receive early prenatal care in 19__." This performance measure will assist in leading to [the health outcome measure of] reducing the rate of infant mortality in the State).

Performance Measurement - The collection of data on, recording of, or tabulation of results or achievements, usually for comparing with a benchmark.

Performance Objectives - A statement of intention with which actual achievement and results can be measured and compared. Performance objective statements clearly describe what is to be achieved, when it is to be achieved, the extent of the achievement, and target populations.

Population Based Services - Preventive interventions and personal health services, developed and available for the entire MCH population of the State rather than for individuals in a one-on-one situation. Disease prevention, health promotion, and statewide outreach are major components. Common among these services are newborn screening, lead screening, immunization, Sudden Infant Death Syndrome counseling, oral health, injury prevention, nutrition and outreach/public education. These services are generally available whether the mother or child receives care in the private or public system, in a rural clinic or an HMO, and whether insured or not.

Pregnant Woman - A female from the time that she conceives to 60 days after birth, delivery, or expulsion of fetus.

Preventive Services - Activities aimed at reducing the incidence of health problems or disease prevalence in the community, or the personal risk factors for such diseases or conditions.

Primary Care - The provision of comprehensive personal health services that include health maintenance and preventive services, initial assessment of health problems, treatment of uncomplicated and diagnosed chronic health problems, and the overall management of an individual's or family's health care services.

Process - Process results are indicators of activities, methods, and interventions that support the achievement of outcomes (e.g., improved health status or reduction in risk factors). A focus on process results can lead to an understanding of how practices and procedures can be improved to reach successful outcomes. Process results are a mechanism for review and accountability, and as such, tend to be shorter term than results focused on health outcomes or risk factors. The utility of process results often depends on the strength of the relationship between the process and the outcome. Process results should answer the question, "Why should this process be undertaken and measured (i.e., what is its relationship to achievement of a health outcome or risk factor result)?"

Process Objectives - The objectives for activities and interventions that drive the achievement of higher-level objectives.

Program Income (as used in the Application Face Sheet [SF 424] and Forms 2 and 3) - Funds collected by State MCH agencies from sources generated by the State's MCH program to include insurance payments, MEDICAID reimbursements, HMO payments, etc.

Risk Factor Objectives - Objectives that describe an improvement in risk factors (usually behavioral or physiological) that cause morbidity and mortality.

Risk Factors - Public health activities and programs that focus on reduction of scientifically established direct causes of, and contributors to, morbidity and mortality (i.e., risk factors) are essential steps toward achieving health outcomes. Changes in

behavior or physiological conditions are the indicators of achievement of risk factor results. Results focused on risk factors tend to be intermediate term. Risk factor results should answer the question, "Why should the State address this risk factor (i.e., what health outcome will this result support)?"

State - As used in this guidance, includes the 50 States and the 9 jurisdictions of the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, the Republic of the Marshall Islands, the Federated States of Micronesia and the Republic of Belau.

State Funds (as used in Forms 2 and 3) - The State's required matching funds (including overmatch) in any given year.

Systems Development - Activities involving the creation or enhancement of organizational infrastructures at the community level for the delivery of health services and other needed ancillary services to individuals in the community by improving the service capacity of health care service providers.

Technical Assistance (TA) - The process of providing recipients with expert assistance of specific health related or administrative services that include; systems review planning, policy options analysis, coordination coalition building/training, data system development, needs assessment, performance indicators, health care reform wrap around services, CSHCN program development/evaluation, public health managed care quality standards development, public and private interagency integration, and identification of core public health issues.

Title XIX, number of infants entitled to - The unduplicated count of infants who were eligible for the State's Title XIX (MEDICAID) program at any time during the reporting period.

Title XIX, number of pregnant women entitled to - The number of pregnant women who delivered during the reporting period who were eligible for the State's Title XIX (MEDICAID) program

Title V, number of deliveries to pregnant women served under - Unduplicated number of deliveries to pregnant women who were provided prenatal, delivery, or post-partum services through the Title V program during the reporting period.

Title V, number of infants enrolled under - The unduplicated count of infants provided a direct service by the State's Title V program during the reporting period.

Total MCH Funding - All the MCH funds administered by a State MCH program which is made up of the sum of the ***Federal*** Title V Block Grant allocation, the ***Applicant's*** funds (carryover from the previous year's MCH Block Grant allocation - the unobligated balance), the ***State*** funds (the total matching funds for the Title V allocation - match and overmatch), ***Local*** funds (total of MCH dedicated funds from local jurisdictions within

the State), ***Other*** Federal funds (monies other than the Title V Block Grant that are under the control of the person responsible for administration of the Title V program), and ***Program Income*** (those collected by State MCH agencies from insurance payments, MEDICAID, HMO's, etc.).

Types of Services - The major kinds or levels of health care services covered under Title V activities. See individual definitions under "Infrastructure Building," "Population Based Services," "Enabling Services," and "Direct Medical Services."

5.2 Assurances and Certifications

ASSURANCES -- NON-CONSTRUCTION PROGRAMS

Note: Certain of these assurances may not be applicable to your project or program. If you have any questions, please contact the Awarding Agency. Further, certain Federal assistance awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the assistance; and will establish a proper accounting system in accordance with generally accepted accounting standards or agency directives.

3. Will establish safeguards to prohibit employees from using their position for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. Sects. 4728-2763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standards for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to non-discrimination. These include but are not limited to (a) Title VI of the Civil Rights Act of 1964 (P.L. 88 Sect. 352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. Sects. 1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. Sect. 794), which prohibits discrimination on the basis of handicaps; (d) The Age Discrimination Act of 1975, as amended (42 U.S.C. Sects 6101 6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office of Treatment Act of 1972 (P.L. 92-255), as amended, relating to non-discrimination

on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to non-discrimination on the basis of alcohol abuse or alcoholism; (g) Sects. 523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. Sect. 3601 et seq.), as amended, relating to non-discrimination in the sale, rental, or financing of housing; (i) any other non-discrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other non-discrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Titles II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply with the provisions of the Hatch Act (5 U.S.C. Sects 1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. Sects. 276a to 276a-7), the Copeland Act (40 U.S.C. Sect 276c and 18 U.S.C. Sect. 874), the Contract Work Hours and Safety Standards Act (40 U.S.C. Sects. 327-333), regarding labor standards for federally assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetlands pursuant to EO 11990; (d) evaluation of flood hazards in flood plains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. Sects. 1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. 7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. Sects 1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers systems

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. Sect. 470), EO 11593 (identification and preservation of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. Sects. 469a-1 et seq.)

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. Sect. 2131 et seq.) pertaining to the care, handling, and

treatment of warm blooded animals held for research, teaching, or other activities supported by the award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. Sects. 4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

18. Will comply will all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

CERTIFICATIONS

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

By signing and submitting this proposal, the applicant, defined as the primary participant in accordance with 45 CFR Part 76, certifies to the best of its knowledge and belief that it and its principals:

(a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
(b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission or fraud or criminal judgment in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
(c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission or any of the offenses enumerated in paragraph (b) of the certification; and
(d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause, titled “Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion -- Lower Tier Covered Transactions” in all lower tier covered transactions (i.e. transactions with sub-grantees and/or contractors) in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for applicant organization) certifies that the applicant will, or will continue to, provide a drug-free workplace in accordance with 45 CFR Part 76 by:

(a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee’s workplace and specifying the actions that will be taken against employees for violation of such prohibition;
(b) Establishing an ongoing drug-free awareness program to inform employees about-
    (1) The dangers of drug abuse in the workplace;

(2) The grantee's policy of maintaining a drug-free workplace,
(3) Any available drug counseling, rehabilitation, and employee assistance programs; and
(4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

(c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;

(d) Notifying the employee in the statement required by paragraph (a) above, that, as a condition of employment under the grant, the employee will-
(1) Abide by the terms of the statement; and
(2) Notify the employer in writing of his or her conviction for violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

(e) Notify the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

(f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d)(2), with respect to any employee who is so convicted-
(1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended, or
(2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

(g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Division of Grants Policy and Oversight
Office of Management and Acquisition
Department of Health and Human Services
Room 517-D
200 Independence Avenue, S.W.
Washington, D.C. 20201

3. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled “Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,” generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. The requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
(2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, “Disclosure of Lobbying Activities,” in accordance with its instructions. (If needed, Standard Form-LLL, “Disclosure of Lobbying Activities,” its instructions, and continuation sheet are included at the end of this application form.)
(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent

statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also know as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18 if the services are funded by Federal programs either directly or through State or local governments by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable Federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing this certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Service strongly encourages all grant recipients to provide a smoke free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of American people.

5.3 Other Supporting Documents

5.4 Core Health Status Indicator Forms

5.5 Core Health Status Indicator Detail Sheets

5.6 Developmental Health Status Indicator Forms

5.7 Developmental Health Status Indicator Detail Sheets

5.8 All Other Forms

5.9 National Core Performance Measure Detail Sheets

5.10 State Negotiated Performance Measure Detail Sheets

5.11 Outcome Measure Detail Sheets